

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
Hannah				Abelman	April 21 1968		6:35 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		White		Sept. 15, 1882		85					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Russia		U.S.A.				Montgomery		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Kensington		Kensington Gardens Sanitarium		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
				Washington, D.C.				2939 Van Ness St., N.W.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Louis				Dorfman	Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				Unknown		Norakreger		2939 Van Ness St., N.W.		Wash. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebral</u> <u>437.9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>334 X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16, 1966</u> to <u>4/21, 1968</u> , that (I) (we) lost saw the deceased alive on <u>4/21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
<u>[Signature]</u>		<u>4/21/68</u>			<u>W.F. Kneezburg</u>		<u>1752 16th St W</u>		<u>Wash. D.C.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
<u>BURIAL</u>		<u>4-23-68</u>		<u>D.C. LODGE CEM.</u>		<u>WASH., D.C.</u>					
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>Goldberg Funeral Home</u>		<u>4217-94 St.</u>			DATE <u>APR 24 1968</u>		<u>Charles Judge</u>				

03730



Handwritten text at the top left, possibly a date or reference number.

Several lines of faint, mostly illegible handwritten text in the upper middle section.

More lines of faint, mostly illegible handwritten text in the middle section.

Additional lines of faint, mostly illegible handwritten text in the lower middle section.

Bottom section containing faint, mostly illegible handwritten text, possibly a signature or concluding remarks.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)		First Ernest		Middle Peter		Last Abelson		2a. DATE OF DEATH Month Day Year April 20 1968		2b. HOUR 11:25 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 28 July 1930		6. AGE (In years last birthday) 37 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Consultant		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Garrett Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10704 Clermont Avenue					
14. FATHER'S NAME First Middle Last John H. Abelson		15. MOTHER'S MAIDEN NAME First Middle Last Kate Pinner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes						16b. SOCIAL SECURITY NO. 318-26-022		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> 2040 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Lymphocytic Leukemia</b> 2043 DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 2043													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 March, 1968, to 20 April, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 20 April, 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.													
22b. SIGNATURE Robert C. Young M.D.		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 20 April 1968			
22d. PHYSICIAN'S NAME (Type) Robert C. Young, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/22/68		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN		23d. LOCATION (City or Town) c (County) (State) FALLS CHURCH Va.							
24. FUNERAL DIRECTOR B. Dampier & Sons 3501 14th St NW WASH. D.C.		25a. REC'D BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge									



Proposed amendments, bilateral  
treaties between the Republic

*Robert C. Young, Jr.*

Robert C. Young, Jr.



AN large consultant Dr. Ball  
on the case.

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CERTIFICATE OF DEATH

05765

1. DECEASED-NAME (Type or print) <i>Alfred A Abernathy</i>		2a. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1968</i>		2b. HOUR <i>3:56 PM</i>
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>December 9-1892</i>	6. AGE (In years lost birthday) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Michigan</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5104 Battery Lane</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Naval Architect</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>See 1.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>5104 Battery Lane</i>
14. FATHER'S NAME <i>Elmer Abernathy</i>	15. MOTHER'S MAIDEN NAME <i>Ella Kingley</i>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>yes</i> (If yes give war or dates of service) <i>1919</i>		
16b. SOCIAL SECURITY NO. <i>303-07-367A</i>		17. INFORMANT <i>Thos Ruth Abernathy - Son</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL VASCULAR ACCIDENT</i> <i>437.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ARTERIOSCLEROTIC CEREBRAL VAS. DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ARTERIOSCLEROSIS GENERAL</i> <i>331X</i> 10 YRS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>SUDDEN</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>DIABETES MELLITUS</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from <i>JUNE 15, 1964</i> , to <i>APRIL 29, 1968</i> , that (I) (we) lost saw the deceased alive on <i>APRIL 16, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Robert G. Angle</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>29 APRIL 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Robert G Angle</i>		22e. ADDRESS <i>5009 Del Ray Ave., Bethesda, Maryland</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May April 3, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Park Lawn Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Montgomery County, Maryland</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 2 1968</i>	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	

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VR 45 (1-68)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Earline Ellsworth Alexander</b>			2a. DATE OF DEATH Month Day Year <b>April 4 1968</b>		2b. HOUR A.M. or P.M. <b>10:15M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>18 December 1906</b>		6. AGE (In years last birthday) <b>61</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Westminster</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>412 Sullivan Road</b>
14. FATHER'S NAME First Middle Last <b>Walter Alexander</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Debow</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-01-6013</b>		17. INFORMANT <b>The Medical Records</b> address <b>The Clinical Center, Bethesda, Maryland 20014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute renal failure with uremia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Primary systemic amyloidosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>4 weeks</b> <b>(months)</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2891</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <b>(A)</b> (this hospital) attended the deceased from <b>25 March</b> , 19 <b>68</b> , to <b>4 April</b> , 19 <b>68</b> , that <b>(A)</b> (we) lost the deceased alive on <b>4 April</b> , 19 <b>68</b> , and that in <b>(A)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James T. Willerson M.D.</b>		22c. DATE SIGNED <b>April 4, 1968</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>	
24. FUNERAL DIRECTOR <b>DD Hartzler &amp; Sons Union Bridge Md</b>		23d. LOCATION (City or Town) (County) (State) <b>NEW WINDSOR RURAL MD</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>APR 8 - 1968</b>			

05703

STATE OF OHIO

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John A. ...

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05766 CERTIFICATE OF DEATH 05767									
1. DECEASED-NAME (Type or print) First Middle Last <b>Margaret Walker Arbuthnot</b>					2a. DATE OF DEATH <b>4 Month 3 Day 68Year</b>		2b. HOUR <b>9<sup>45</sup> A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caus.</b>		5. DATE OF BIRTH <b>8/23/1881</b>		6. AGE (In years last birthday) <b>86 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Great Britain</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>University Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>229 Rock Creek Church Rd., N.W.</b>	
14. FATHER'S NAME First Middle Last <b>John William Arbuthnot</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Isabella Jolliffe</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-66-4569</b>		17. INFORMANT <b>Louise Venz</b>		Address <b>Same as #13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bronchitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>3-11-1968</b> , to <b>4-3-1968</b> , that (I) (we) last saw the deceased alive on <b>4-1-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Myron L. Lenkin</b>				DEGREE <b>Myron L. Lenkin</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/3/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Myron L. Lenkin</b>				22e. ADDRESS <b>2309 Shorfield Rd. Wheaton, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-5-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>			
24. FUNERAL DIRECTOR <b>F.J. COLLINS-3821-14th ST. N.W. WASH. D.C.</b>				25a. REC'D BY REGISTRAR <b>8 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



15737

OFFICE OF DEATH

15737

DATE OF DEATH: 1944

PLACE OF DEATH: 1944

CAUSE OF DEATH: 1944

DATE OF BURIAL: 1944

PLACE OF BURIAL: 1944

NAME OF DECEASED: 1944

AGE OF DECEASED: 1944

SEX OF DECEASED: 1944

RACE OF DECEASED: 1944

RELIGION OF DECEASED: 1944

EDUCATION OF DECEASED: 1944

OCCUPATION OF DECEASED: 1944

DATE OF BIRTH: 1944

PLACE OF BIRTH: 1944

DATE OF DEATH: 1944

PLACE OF DEATH: 1944

CAUSE OF DEATH: 1944

DATE OF BURIAL: 1944

PLACE OF BURIAL: 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <b>ELIZABETH</b>		Middle <b>E</b>		Last <b>ARMHOLD</b>		2a. DATE OF DEATH Month Day Year <b>APRIL 13 1968</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 25, 1879</b>			6. AGE (In years last birthday) <b>88</b> YRS.		2b. HOUR <b>6:30 AM</b>		
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery Co.</b>				
10. CITY OR TOWN OF DEATH <b>Kensington</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Hall San. Hm.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Washington, DC.</b>			13b. COUNTY <b>Dist. of Columbia</b>		13c. CITY OR TOWN <b>District</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2440 - 16th St., N.W.</b>		
14. FATHER'S NAME First Middle Last <b>William Read</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Anna Graham</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-03-1850</b>		17. INFORMANT <b>3200 - Curtis Dr Marlow Heights, Md</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201 SENILITY</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 29, 1967</b> , to <b>APRIL 13 1968</b> , that (I) (we) last saw the deceased alive on <b>APRIL 13 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Henry M. Lowden M.D.</b>					DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		22c. DATE SIGNED <b>4/13/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Henry M. Lowden</b>					22e. ADDRESS <b>5206 Norway Dr. Chevy Chase, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>April 16, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>				
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>					ADDRESS <b>Wash., SE DC.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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STATE OF TEXAS

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CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>GEORGE EDWIN ARMSTRONG</b>			2a. DATE OF DEATH 4 Month 26 Day 68 Year			2b. HOUR 10 <sup>00</sup> AM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH 7-4-96		6. AGE (In years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH SAN &amp; HOSP</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>File Clerk Veterans Administration</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>10120 NEW HAMPSHIRE AVE</b>		14. FATHER'S NAME First Middle Last <b>Isaac Armstrong</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Martha Mayberry</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>		16b. SOCIAL SECURITY NO. <b>332-03-7156</b>		17. INFORMANT <b>WIFE Lilly M. Armstrong</b> Address <b>10120 New Ham. Ave. S.S. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular brain disease with congestive failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4200</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 16, 1968</b> to <b>April 26, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Boris Rabkin</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>4-26-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>BORIS RABKIN, M.D.</b>				22e. ADDRESS <b>1019 University Blvd, East S.S.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 30 '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
23e. FUNERAL DIRECTOR <b>C. Glen Carter, Warner E. Pumphrey, Inc. Silver Spring, Md.</b>				23f. ADDRESS <b>1134 Georgia Avenue</b>		23g. REC'D BY REGISTRAR <b>Charles Judge</b>	
23h. DATE <b>MAY 01 1968</b>				23i. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

in 0.00 after lunch

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George Edwin Armstrong  
M. W. 1-4-20  
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KENTON  
ACU  
TAKOMA PARK  
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WIFE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Grover Ernest Asmus						Month 4 Day 17 Year 68			732 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		Feb. 11, 1885		83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Potomac Valley Road - N.A.		Retired Bacteriologist					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Bethesda				7513 New Market Drive Bethesda, Md.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Ernest G. Asmus			First Middle Last Josephine Lung						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			- - - - -			R. Wentworth 7513 New Market Drive Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARDIAC ARREST									
4129 DUE TO, OR AS A CONSEQUENCE OF									
(b) CONGESTIVE HEART FAILURE 24 HRS									
DUE TO, OR AS A CONSEQUENCE OF									
(c) ARTERIO SCLEROTIC HEART DISEASE 5 YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4200 GENERALIZED ARTERIO SCLEROSIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from APRIL 15, 1967, to APRIL 17, 1968, that (I) (we) lost saw the deceased alive on APRIL 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
I honor to Thomas M.D.		4/17/68		THOMAS F. O'CONNOR M.D.					
22e. ADDRESS		22f. ADDRESS							
		8218 WILSONS AVE BETHESDA, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 20, 1968		Flower Hill Cemetery		North Bergen, New Jersey			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C. Glen Carter Warner E. Pumphrey, Inc.		8434 Georgia Avenue Silver Spring, Md.		DATE APR 22 1968		Charles Judge			

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CERTIFICATE OF DEATH

03770



Death Date and Time Entered

Place of Death and Burial

Age

8288 10 10 1968

10 10 1968

10 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR Min.
BARBARA F. ATWOOD						APRIL 14 1968			11:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		9-2-1915		52 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Mass		U.S.A				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			SUBURBAN Hosp.			SECRETARY		SCHOOL	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND			Montgomery			Potomac		9201 MARSEILLE Dr.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry H. Farwell			Anna Le Hand						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			023.03.6870			Husband William Atwood			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastasis to bone, 5 MO (c) Liver & Lungs 4 MO								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Dec 1965, to 4/14, 1968, that (I) (we) last saw the deceased alive on 4/14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. J. Brennan					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/15/68		
22d. PHYSICIAN'S NAME (Type) A. J. Brennan					22e. ADDRESS Cherry Chase Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-19-68		Mt. Auburn Cemetery		Cambridge, Mass.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 2a Film G399 1/15/68 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05772 05768 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>Edith Enquist Humen</i>			2a. DATE OF DEATH April 5 1968 Month Day Year			2b. HOUR 1:30 P.M.					
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>3/13/1896</i>		6. AGE (In years last birthday) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Conn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>none</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>13013-Scarlet Oaks</i>			
14. FATHER'S NAME First Middle Last <i>Charles Enquist</i>			15. MOTHER'S M maiden name First Middle Last <i>unknown</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Wm. C. Humen</i>		Address <i>same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asystole</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4109</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i> <i>no</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1967</i> , to <i>April 5, 1968</i> , that (I) (we) last saw the deceased alive on <i>Dec 27, 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William Henry Kelly MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>April 5 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Kelly</i>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-9-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Blue Bell</i>		23d. LOCATION (City or Town) (County) (State) <i>BrainTree, N.Y. Mass</i>					
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>				ADDRESS <i>Gaithersburg, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Jones</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			
						DATE <i>APR 11 1968</i>					



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WALTON, CLARA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05770

05773

1. DECEASED-NAME (Type or print) <b>Edith</b> <b>(none)</b> <b>Bailey</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1968</b>		2b. HOUR <b>12:30</b> <sup>A</sup>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>December 1, 1900</b>		6. AGE (In years last birthday) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	7b. CITIZEN OF WHAT COUNTRY? <b>America</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanitarium &amp; Hosp.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Washington D.C.</b>	13b. COUNTY <b>D.C.</b>	13c. CITY OR TOWN <b>D.C.</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1133 13th Street: N.W.</b>	
14. FATHER'S NAME First <b>George</b> Middle <b>Powers</b> Last <b>Mary</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Address</b> Last <b>Address</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. <b>114-30-9606</b>	17. INFORMANT <b>Patient's chart</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Colon - Extensive</b> <b>153.8</b> DUE TO, OR AS A CONSEQUENCE OF <b>Metastasis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>153.8</b>					
19a. DATE OF OPERATION <b>Apr. 9/68</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Colon</b>	20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Apr. 5</b> , 19 <b>68</b> , to <b>Apr. 23</b> 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>Apr. 22</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Herman I. Slate, MD.</b>	DEGREE <b>MD.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>4-23-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>HERMAN I. SLATE</b>	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Apr. 29, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>		
24. FUNERAL DIRECTOR <b>Arthur Walters</b>	ADDRESS <b>234 Carroll St. N.W. Wash DC</b>	25a. RECD BY REGISTRAR <b>APR 30 1968</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Violet G. Barnum</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>5:45</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>FEB. 11. 1896</b>		6. AGE (In years lost birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Silver Springs</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fairland Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>TAK. PK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>22 GRANT AVE</b>	
14. FATHER'S NAME First Middle Last <b>COURIS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>WILHELMINA</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>WILLIAM L. BARNUM, 22 GRANT AVE TAK PK</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast with metastases</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>about 1 1/2 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>170X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1967</b> to <b>19 April 1968</b> , that (I) (we) last saw the deceased alive on <b>19 April 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William D. Aud</b>				22c. DATE SIGNED <b>4/19/68</b>		22d. PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>April 22, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville Mont. Md.</b>		23e. REC'D BY REGISTRAR <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Arthur Waters</b>		24a. ADDRESS <b>254 Carroll St. N.W.</b>		24b. CITY <b>Washington, D.C.</b>		24c. STATE <b>D.C.</b>		24d. ZIP CODE <b>20002</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 4-13 (A)  
30M REV. 7-1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Charlie Washington</b>		First Middle Last		2a. DATE OF DEATH Month Day Year <b>April 8 1968</b>		2b. HOUR <b>1:50 A.M.</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>5/15/1903</b>		6. AGE (In years last birthday) <b>65</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Rockville Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Damascus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>25500 Oak Dr.</b>		14. FATHER'S NAME First Middle Last <b>George Baugher</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Josephine Lawson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>225-24-4686</b>		17. INFORMANT Address <b>Mrs Bessie F. Baugher, Damascus, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic squamous cell carcinoma</b> <b>173.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>91.90 cerebral arteriosclerosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-4</b> , 19 <b>68</b> , to <b>4-5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-4</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>DL Bucy / SN Jones</b>		22c. DATE SIGNED <b>4-5-68</b>		22d. PHYSICIAN'S NAME (Type) <b>DL Bucy / SN Jones</b>			
22e. ADDRESS <b>809 Veirs Mill Rd Rockville Md</b>		22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 8, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Md.</b>	
24. FUNERAL DIRECTOR Address <b>Olin L. Molesworth, Damascus, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 9 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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UNITED STATES

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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C. 20530

UNITED STATES DEPARTMENT OF THE INTERIOR

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OFFICE OF THE ASSISTANT ATTORNEY GENERAL

WASHINGTON, D. C. 20530

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05772

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1. DECEASED-NAME (Type or print) <b>Fletcher D. Bennett</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1968</b>			2b. HOUR <b>1:00</b> A.M.				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 15, 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Boyd</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Boyd-Clarksburg Rd.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Boyd</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Boyd-Clarksburg Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Samuel Bennett</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ann Summers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-48-3127</b>		17. INFORMANT Address <b>Leroy F. Bennett, Boyd, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced Arteriosclerotic Cardio-vascular-renal</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF <b>Disease with Moderate Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>472x</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>No accident.</b>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) <del>(did not)</del> attended the deceased from <b>1950</b> , 19____, to <b>April 5, 1968</b> , that (I) <del>(was not)</del> saw the deceased alive on <b>April 4, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(deed)</del> view the body after death.										
22b. SIGNATURE <b>M. McKendree Boyer, M.D.</b>					22c. DATE SIGNED <b>April 5, 1968</b>		22d. ADDRESS <b>9701 Church Street Damascus, Maryland.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clarksburg Meth.</b>		23d. LOCATION (City or Town) (County) (State) <b>Clarksburg, Md.</b>				
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>APR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

98778

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

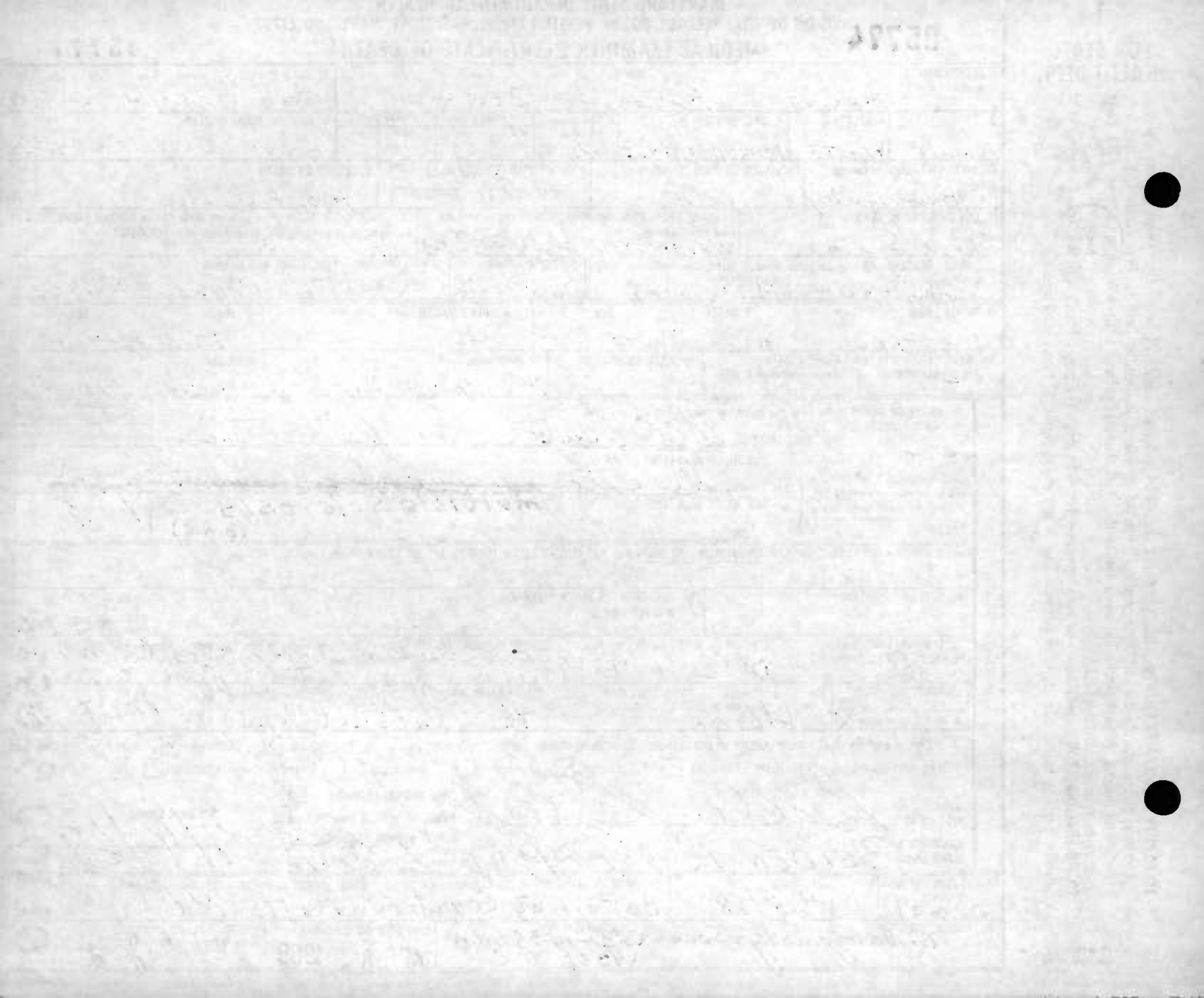
05774

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05777

1. DECEASED-NAME (Type or Print) <b>MAXINE KATE BERG</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>April</b> Day <b>4</b> Year <b>1968</b>			2b. HOUR <b>12 (M)</b>		
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>MARCH 31, 1920</b>	6. AGE (In years lost birthday) <b>48 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>April</b> Day <b>4</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Brooklyn, N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON SANITARY Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House wife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>9630 CATHRELL TERRACE</b>
14. FATHER'S NAME First <b>FRED</b> Middle <b>H.</b> Last <b>SMITH</b>			15. MOTHER'S MAIDEN NAME First <b>ANNE</b> Middle <b>DUBERSTEIN</b> Last <b>DUBERSTEIN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>MR. Stanley BERG, 9630 Cathrell Terr. S.S.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental Suffocation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>9/13.0</b> (b) <b>due to multiple sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>(B.R.R.)</b> (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>924.0</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>APRIL 4-4-1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>deceased unable to move and prevent suffocation in bed</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>			21f. LOCATION Street or R.F.D. No. <b>9630 Cathrell Terr., S.S., Montg. Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Belden R. Reap</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>4/4/68</b>		
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>4/8/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cemetery</b>		
						23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR <b>B. Wanzanovsky &amp; Sons</b>			ADDRESS <b>3501-14th St. N.W. Wash. D.C.</b>			25a. REC'D BY REGISTRAR <b>APR 8 - 1968</b>		
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05775

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05778

1. DECEASED-NAME (Type or Print)			First Prosper Middle Felix Last Biauce			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year 1968			2b. HOUR 8 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2/5/1899		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Penn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH en route to hospital				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) - Montgomery General				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) caretaker				12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Montgomery				13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2201 Ednor Road	
14. FATHER'S NAME First Constantine Middle Biauce Last			15. MOTHER'S MAIDEN NAME First Mary Middle ( Unknown ) Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. 286-01-7552				17. INFORMANT Medical records ADDRESS Montgomery Genl. Hospital, Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				Belden R. Reap, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4-8-68		23c. NAME OF CEMETERY OR CREMATORY Laytonsville				23d. LOCATION (City or Town) (County) (State) Laytonsville, Mont., Md.			
24. FUNERAL DIRECTOR Francis H. Barber						ADDRESS Laytonsville, Md.							
25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE Charles Judge							
DATE APR 10 1968													

08375

General - [illegible]

(Unknown)

Lynchville, N.H., Md.

Lynchville

1-8-68

Serial

Lynchville, Md.

Francis H. Barber

Apr 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 41514  
 30M REV. 1/68

05776

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05779

1. DECEASED-NAME (Type or print)		First RUBY	Middle C.	Last BISHOP	2a. DATE OF DEATH Month Day Year April 2, 1968		2b. HOUR 7:00 PM		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH Sept. 12, 1884		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 3305 Turner Lane		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3305 Turner Lane	
14. FATHER'S NAME First Middle Last William D. Shaver			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Weldon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-54-8978		17. INFORMANT Husband Walter E. Bishop			Address Same as Item 13.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 436.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 331X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>Apr 2</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>April 2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Ronald W. Barr</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) RONALD W. BARR				22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-5-68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE APR 9 - 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

DEPARTMENT OF HEALTH

05533

15778

Prothonotary Notary  
Prothonotary  
Prothonotary

April 18 1907

Prothonotary



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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VR 10-1 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Christiana Dorothea Boswell			2a. DATE OF DEATH Month Day Year April 29 1968			2b. HOUR 8:45 P			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 6, 1886		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Postmistress		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7303 Delfield street	
14. FATHER'S NAME First Middle Last Charles F. Andreae			15. MOTHER'S MAIDEN NAME First Middle Last Amelia Mechtold						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT records Montgomery Gen. Hospital, Olney, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4129 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u> <u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>4200</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>62</u> , to <u>4-29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Luciano I. Leal</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) Luciano I. Leal, M.D.					22e. ADDRESS 108 N. Frederick av., Gaithersburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/2/68		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks West Inc Balt. Md. 21228				25a. REC'D BY REGISTRAR DATE MAY 6 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10 FEB 1964

MINISTRY OF DEFENSE

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10 FEB 1964

10 FEB 1964 MINISTRY OF DEFENSE 00000 10 FEB 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Elsie Devona Brady						April 7 68			4:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		white		11-16-82		85 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pa.		Amer.				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Washington Sanitarium Hosp.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Prince Georges		Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		386 Old Line Ave		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Rapph					Weyan	Anna					Parks
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
no			220-34-7703			Med Records - W. S. H.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 437.9 Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331x (b) Arteriosclerosis, Cerebral DUE TO, OR AS A CONSEQUENCE OF (c) Age APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 85 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Recent right colon resection for Ca. of Cecum											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
March 1, 1968			Carcinoma of Colon			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		no			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 20, 1968, to April 7, 1968, that (I) (we) last saw the deceased alive on April 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. S. H.						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 7, 1968	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
April 11-1968					Oak Ridge Cemetery		Altoona, Penna.				
24. FUNERAL DIRECTOR Arthur Walters						ADDRESS 254 Carroll St		25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05779

05782

1. DECEASED NAME (Type or print)		First <b>CLARA</b>	Middle <b>lucy</b>	Last <b>BREIBY</b>		2a. DATE OF DEATH Month <b>7</b> Day <b>18</b> Year <b>67</b>		2b. HOUR <b>6:15</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 29, 1889</b>		6. AGE (In years lost birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Canada</b>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bethesda Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8912 Fairview</b>	
14. FATHER'S NAME First <b>Ukn.</b>		Middle <b>Ukn.</b>		Last <b>Ukn.</b>		15. MOTHER'S MAIDEN NAME First <b>Ukn.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Nursing Home records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of Bant</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory Distressing</b> <b>3 yr</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>170X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , to <b>April, 1967</b> , that (I) (we) lost saw the deceased alive on <b>4/11/67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. Tabb Moore</b>		DEGREE <b>W. TABB MOORE</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>2001 I St NW WASH, D.C.</b>		22c. DATE SIGNED <b>4/18/67</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>4/18/78</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematorium</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>			
24. FUNERAL DIRECTOR <b>Lee Funeral Home, Washington, D.C.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>APR 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



83738

UNITED STATES OF AMERICA

Office of the  
Attorney General

Washington, D.C.

February 20, 1934

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 17th inst.

in relation to the matter of the

proposed amendment to the

constitution of the

State of California.

The same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

Wm. C. Clegg

Special Agent in Charge

United States Department of Justice

Washington, D.C.

Enclosed for you are

two copies of the

proposed amendment to the

constitution of the

State of California.

Very truly yours,

Wm. C. Clegg

Special Agent in Charge

United States Department of Justice

Washington, D.C.

Enclosed for you are

two copies of the

proposed amendment to the

constitution of the

RECEIVED  
FEB 21 1934  
U.S. DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Edna</i> First Middle Last <i>A Brewer</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>9</i> Year <i>1968</i>			2b. HOUR <i>7:15</i> M			
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>Oct 21 1900</i>		6. AGE (in years last birthday) <i>67</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Oklahoma</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4615 Rosbury Dr.</i>	
14. FATHER'S NAME First <i>Levi</i> Middle <i>Ackley</i> Last <i>Mary</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Laticus</i> Last <i>Laticus</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>John B. Brewer</i> Address <i>Same as Item 13.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary arteriosclerosis and insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>70 DAYS</i> <i>10 YRS.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4201</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/31/68</i> , 19__, to <i>4/9/68</i> , 19__, that (I) (we) saw the deceased alive on <i>4/8/68</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Henry C. Scruggs MD</i> DEGREE <i>MD</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/9/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>HENRY C. SCRUGGS MD</i>				22e. ADDRESS <i>5413 Cedar Lane Bethesda MD.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-11-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>APR 15 1968</i> DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

100-100000

RECORDS OF DEATH

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Geoffrey H. BRIGGS</b>		2a. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1968</b>		2b. HOUR <b>754A</b> M.
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Aug. 16, 1929</b>	6. AGE (In years lost birthday) <b>38</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>California</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U. S. Coast Guard</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>	13b. COUNTY <b>Arlington</b>	13c. CITY OR TOWN <b>Arlington</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5701 North 16th Street</b>
14. FATHER'S NAME First <b>Lloyd S.</b> Middle <b>Briggs</b> Last	15. MOTHER'S MAIDEN NAME First <b>Helen</b> Middle <b>Ward</b> Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>1946-1968</b>	17. INFORMANT <b>Arlington, Va.</b> Address <b>Mrs. Claudia M. Briggs, 5701 North 16th St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal and gastrointestinal hemorrhage, massive</b> <b>5770</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pancreatitis, acute, hemorrhagic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Subphrenic abscess</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>587.0</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Mar. 22</b> , 19 <b>68</b> , to <b>April 2</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 2</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <del>not</del> view the body after death.				
22b. SIGNATURE <i>C. M. Herman</i>	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>April 2, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>C. M. Herman, M. D.</b>	22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4/8/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Falls Church Funeral Home</b> <b>1102 West Broad Street, Falls Church, Va.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 5 - 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





## CERTIFICATE OF DEATH

05782

05785

1. DECEASED-NAME (Type or print) <b>CATHERINE HOVELL BROCK</b>			2a. DATE OF DEATH Month Day Year <b>Apr. 6, 1968</b>			2b. HOUR <b>8:10 P.</b>			
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>July 29, 1884</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Hall N. H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8608 Fenway Road</b>	
14. FATHER'S NAME First Middle Last <b>Peter Hovell</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Agnes (Unknown)</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Husband</b>		Address <b>Same as Item 13.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>485x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>491x Arteriosclerosis Cardiovascular Disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <b>6/4/67, 1967</b> , to <b>APRIL 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>APRIL 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen W. Deiter M.D.</b>					22c. DATE SIGNED <b>4-6-1968</b>		22d. PHYSICIAN'S NAME (Type) <b>STEPHEN W. DEITER M.D.</b>		
22e. ADDRESS <b>6719 WILSON LA, BETHESDA, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Willow Brook Cem.</b>		23d. LOCATION (City or Town) <b>Westport, Conn.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>APR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Jones</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15/15/18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

05782		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05786		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		
Lillian Katherine Brown						Apr Month 16 Day 1968		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		
F		W		Sept. 30, 1887		80 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Delaware		U. S. A.				Montgomery Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg		Asbury Methodist Home		Telephone operator				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland		Queen Anne		Crumpton				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		
Samuel D. Sterling						Elmyra Sterling		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO.		17. INFORMANT			
			214-34-5381		A Asbury Methodist Home, Gaithersburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332x Diabetes Mellitus						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS. 6 YRS.		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4/1/63, 19__, to 4/16/68, 19__, that (I) (we) last saw the deceased alive on 4/16/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Henry C. Scruggs MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/16/68		
22d. PHYSICIAN'S NAME (Type) Henry C. Scruggs MD				22e. ADDRESS 5413 Cedar Lane Bethesda Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4-19-68		Crumpton Church		Crumpton Queen Anne, Md		
24. FUNERAL DIRECTOR Ernest S. Gartner				ADDRESS Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE Apr 22 1968		
						25b. REGISTRAR'S SIGNATURE Charles Judge		

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CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>Emma F. Burch</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>68</b>			2b. HOUR <b>11:00</b> P. M.	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>4-27-05</b>		6. AGE (In years last birthday) <b>62</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Wash D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dairy Co.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Derwood</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>16940 Baederwood Lane</b>	
14. FATHER'S NAME First <b>Perry</b> Middle <b>Smith</b> Last			15. MOTHER'S MAIDEN NAME First <b>Eva Mae</b> Middle <b>Shorter</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-05-2781</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Intracerebral Hemorrhage</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Subarachnoid Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive Arteriosclerotic Heart Dis;</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>443X Bilateral Lobular Pneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/12</b> , 19 <b>68</b> , to <b>4/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Barton J. Gershen M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-13-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>BARTON J. GERSHEN</b>		22e. ADDRESS <b>50 W. Edmonston Ave. Rockville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-16-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>APR 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



High Intracerebral hemorrhage

Subarachnoid hemorrhage

Hypertensive retinopathy

Bilateral lobular pneumonia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 416 (4)  
30M REV. 1-7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First ELIZABETH	Middle C.	Last BURGESS	2a. DATE OF DEATH Month Day Year Apr. 3, 1968		2b. HOUR 4:35M
3. SEX Female	4. RACE Cauc.		5. DATE OF BIRTH Oct. 6, 1908		6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Country Club Employee		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 12200 Glen Road							
14. FATHER'S NAME First Middle Last John Albert Jefferies			15. MOTHER'S MAIDEN NAME First Middle Last Jenny Sinclair				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 229-18-5831		17. INFORMANT Husband Douglas M. Burgess		Address Same as Item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Meningitis Staphylococcal</i> 320.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 340.2 (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Deslutes Mellitus Desecogenic Disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>26 March, 1968</i> to <i>3 April, 1968</i> , that (I) (we) last saw the deceased alive on <i>Apr. 3, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W. S. Murphy</i>		22c. DATE SIGNED 4-4-68		22d. PHYSICIAN'S NAME (Type) WILLIAM S. MURPHY			22e. ADDRESS 615 W. Montgomery Ave. Rockville, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-6-68		23c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		23d. LOCATION (City or Town) (County) (State) Darnestown, Maryland	
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE APR 9 - 1968		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	

03785

OFFICE OF THE ATTORNEY GENERAL  
STATE OF NEW YORK  
ALBANY

03785

IN SENATE  
JANUARY 1, 1903

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1902

ALBANY: JAMES B. LEECH, STATE PRINTER, 1903.

THE COMMISSIONER OF THE LAND OFFICE

JOHN W. ALLEN, COMMISSIONER

ALBANY: JAMES B. LEECH, STATE PRINTER, 1903.

ALBANY: JAMES B. LEECH, STATE PRINTER, 1903.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Patricia Marie Burnham						MATED <input checked="" type="checkbox"/> APR 11 1968			8:22 AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Fe-	w.	APR 3 1940	28 YRS.	MONTHS	DAYS	HOURS	MIN.	APR 11 1968	8:12 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Linden Hill Hotel			Teacher			Public Schools
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
New York			Queens			Forrest Hills		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
John Flynn			Attracta Dougherty			6242 Ellwell Crescent.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
no						Capt. Robert F. Burnham = same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									Sudden.
IMMEDIATE CAUSE (a) Multiple Injuries Severe.									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Fell from seventh floor of Hotel.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
978X									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			8:05 PM 4-11 1968		Jumped from Window on Seventh floor of Hotel				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Hotel		Linden Hill Hotel		Bethesda		Montgomery Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. DATE SIGNED			22c. CHIEF MEDICAL EXAMINER						
APR 11 1968			John S. Ball M.D.						
22d. DEPUTY MEDICAL EXAMINER			22e. ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		16 Apr 68		Arlington Nat'l Cem.			Arlington, Virginia		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Falls Church F.H., Falls Church, Va.				DATE APR 15 1968			Charles Judge		

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TO THE  
HONORABLE  
MEMBERS OF THE  
HOUSE OF REPRESENTATIVES  
WASHINGTON, D. C.  
JANUARY 10, 1908  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 7th inst. in relation to the matter of the proposed amendment to the Constitution of the United States, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
J. M. [Signature]  
J. M. [Signature]  
J. M. [Signature]

Enclosed for the  
Honorable [Name]  
[Address]  
[City, State]  
[Country]

Very truly yours,  
J. M. [Signature]  
J. M. [Signature]  
J. M. [Signature]



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Mary C. Burns</b>		2a. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>68</b>		2b. HOUR <b>8:00</b> M
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Mar. 23, 1879</b>	6. AGE (In years last birthday) <b>89</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Aberdeen, Miss.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley N.H.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>	13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Washington</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>4816 Quebec St. NW</b>
14. FATHER'S NAME <b>James W. Carter</b>	15. MOTHER'S MAIDEN NAME <b>Mary Sue Tindall</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16b. SOCIAL SECURITY NO. <b>496-30-3635</b>	17. INFORMANT <b>Carter Burns</b>	Address <b>see # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>079.9 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>096.9 dehydration</b> (b) <b>Intestinal Virus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Aspergillus</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>4 days</b> <b>6 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Aspergillus</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>67</b> , to <b>April</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>W. S. Murphy MD</b>	22c. DATE SIGNED <b>5 April 68</b>	22d. PHYSICIAN'S NAME (Type) <b>William Murphy MD</b>	22e. ADDRESS <b>West Montgomery Av., Rockville, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial/Removal</b>	23b. DATE <b>4/7/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine</b>	23d. LOCATION (City or Town) (County) (State) <b>St. Louis, Missouri</b>	
24. FUNERAL DIRECTOR <b>Jos. Gawler's Sons</b>	24a. ADDRESS <b>5130 Wisconsin Av., NW Washington, D.C.</b>	25a. REC'D BY REGISTRAR <b>DATE APR 10 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



UNITED STATES OF AMERICA

00730

APR 10 1980

05788

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05791

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
ROBERT EMMETT BURNS, JR.								<input checked="" type="checkbox"/> Month Day Year April 25 1968		10:37 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	4-26-06		61 YRS		MONTHS DAYS		HOURS MIN.		Month Day Year April 25 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		2d. HOUR	
Maryland		U.S.A.		WIDOWED		DIVORCED		Montgomery		10:37 PM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington San. & Hosp.		Printer		Merkle Press					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		P.G.		Adelphi		YES <input type="checkbox"/> NO <input type="checkbox"/>		8037 New Riggs Rd.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Robert Emmett Burns, Sr.								Nellie		Sharpe	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
None		223-07-8918		Mrs. Margaret Burns, Wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
4129				Acute Coronary Insufficiency		Coronary Artery Heart Disease					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)		4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
ACTUAL SIGNATURE		Belden R. Reap		M.D.		ADDRESS (Street, city, town, or county)		4/26/1968			
EXAMINER'S NAME (Type)		Belden R. Reap, M.D.									
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Cremation		4-29-1968		Cedar Hill		Suitland Pr		George Md			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. H. Mattingly		131-11th St Wash, DC		APR 29 1968		Charles Judge					

63722

THE UNIVERSITY OF CHICAGO

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COLLEGE

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# FOR-STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) <b>NELLIE MAE BYERS</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>6</b> Year <b>1968</b>			2b. HOUR <b>5:30</b> P.M.				
3. SEX <b>FE.</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>8-11-20</b>	6. AGE (In years last birthday) <b>47</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>6</b> Year <b>1968</b>		2d. HOUR <b>5:30</b> P.M.		
7a. BIRTHPLACE (State or foreign country) <b>Mo.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.				
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH. SAN. &amp; HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. OF LABOR</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Mo.</b>			13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>HYATTS.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1452 KANAWHA ST.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>T.</b> Last <b>Hiser</b>			15. MOTHER'S MAIDEN NAME First <b>Nellie</b> Middle <b>Wire</b> Last <b>Wire</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-18-9244</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Failure due to</b> <b>9500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Barbiturate Overdose</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9702</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>3-27 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased took overdose of Seconal &amp; Antiver</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>Hyattsville PG Md</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Belden R. Reap M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>APRIL 6, 1968</b>				
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, City, Town, or County)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem. Washington D.C.</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>				
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Inc.</b>			ADDRESS <b>1400 Chapin St. N.W. Wash. D.C.</b>			25a. REC'D BY REGISTRAR <b>APR 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR P M
James Kenneth Cairns						April 2 1968			8:25 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		White		8 July 1924		43 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			The Clinical Center, NIH			Postal Clerk			US Post Office
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Pennsylvania					Patton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		R. D. 1, Box 7
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James J. Cairns			Cecilia Cassidy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Records Address				
Yes 1943-45			Not available		The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>									4 hours
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Coronary artery disease, (severe)</u>									2 years
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)									
420.1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>XX</del> (this hospital) attended the deceased from <u>March 18</u> , 19 <u>68</u> , to <u>April 2</u> , 19 <u>68</u> , that <del>XX</del> (we) last saw the deceased alive on <u>April 2</u> , 19 <u>68</u> , and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>XX</del> (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
								3 April 1968	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
John Paul Gomstock, MD.		The Clinical Center, National Institutes of Health, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-6-68		St. Mary's Cemetery		Cambria County, Penna.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland				DATE APR 9 - 1968					





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05791

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05794

1. DECEASED-NAME (Type or print) <i>MARIE Doubet CAMAILER</i>			2a. DATE OF DEATH Month <i>Apr.</i> Day <i>7</i> Year <i>1968</i>			2b. HOUR <i>7:50 P.M.</i>					
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>JUNE 14 1880</i>		6. AGE (In years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>ILLINOIS</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. STATES</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>GROSVENOR LANE SAN.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>--</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Washington</i>			13b. COUNTY <i>D. C. U.</i>		13c. CITY OR TOWN <i>---</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3509 LOWELL ST. N.W.</i>		
14. FATHER'S NAME First <i>JOHN</i> Middle <i>Doubot</i> Last <i>CARRIGAN</i>			15. MOTHER'S MAIDEN NAME First <i>VIRGINIA</i> Middle <i>CARRIGAN</i> Last <i>CARRIGAN</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) <i>---</i>			16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT Address <i>DAUGHTER, MRS LUCILLE SIRICA</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129 CONGESTIVE HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CORONARY ART. DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>INTERMITTENT INTEST. OBSTRUCTION</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>10 YRS</i> <i>3 y/2</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>Apr 7</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) lost saw the deceased alive on <i>Apr 7</i> , 19 <i>68</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <i>James J. Foster M.D.</i> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/7/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>James J. Foster M.D.</i>						22e. ADDRESS <i>1746 K ST. N.W.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>4-10-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Md.</i>				
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i> ADDRESS <i>5130 Wisc. Ave. N.W. Wash. D.C.</i>						25a. REC'D BY REGISTRAR DATE <i>APR 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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RECEIVED BY AIR MAIL FROM THE DIRECTOR, NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05792		MARYLAND STATE DEPARTMENT OF HEALTH		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05795	
DECEASED NAME (Type or print) <b>Florence M. Campbell</b>				2a. DATE OF DEATH Month Day Year <b>April 29, 1968</b>		2b. HOUR <b>2 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 9, 1891</b>		6. AGE (In years last birthday) <b>77</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County</b> Md.	
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bethesda Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Wash., D.C.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wash., D.C.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>William R. Campbell</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Pauline Frederick</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>579-60-2051</b>		17. INFORMANT Address <b>Wash., D.C.</b> <b>Helen P. Campbell, Sister, 3700 Van Ness NW</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1540 Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma Recto-sigmoid.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma metastasis Liver.</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>26 mo.</b> <b>6 mo.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e) <b>1548</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 6, 1966</b> , to <b>April 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. W. Damian MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/29/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Jules D. Damian</b>				22e. ADDRESS <b>2741 34th St. N.W.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05792 CERTIFICATE OF DEATH 05796									
1. DECEASED-NAME (Type or print) First Middle Last <i>Edgar Franklin Carnes</i>			2a. DATE OF DEATH Month Day Year <i>April 3 1968</i>			2b. TIME OF DEATH Hour Minute <i>9:15</i>			
3. SEX <i>Male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>2/14/80</i>		6. AGE (In years last birthday) <i>88</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 WEEK HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>London Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Rt 1 Bank Ct.</i>	
14. FATHER'S NAME First Middle Last <i>Eli Carnes</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Fry</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Daughter - Emma Demory</i>		Address: <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ren. Intercapillary</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Age 88 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>331X</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week 10 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>amp B/B - Myocardial Infarction</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or P.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/2/68</i> to <i>4/2/68</i> , that (I) (we) last saw the deceased alive on <i>4/2/68</i> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/2/68</i>			
22d. REGISTRAR'S NAME (Type) <i>Richard Meyers</i>				22e. ADDRESS <i>Old Georgetown Rd., Beth., Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Lovettsville Va</i>			
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>				ADDRESS <i>[Address]</i>		25a. REC'D BY REGISTRAR <i>[Signature]</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
DATE <i>APR 5 - 1968</i>									



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*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

05794										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05797														
1. DECEASED-NAME (Type or print) <i>Annie Velinda Cavanaugh</i>										2a. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1968</i>										2b. HOUR <i>1<sup>st</sup></i> <i>PM</i>														
3. SEX <i>Female</i>					4. RACE <i>White</i>					5. DATE OF BIRTH <i>5/2/88</i>					6. AGE (In years lost birthday) <i>29</i>					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>					7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <i>Montgomery</i>										Md.									
10. CITY OR TOWN OF DEATH <i>Bethesda</i>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>					12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Maryland</i>					13b. CITY <i>Montgomery</i>					13c. CITY OR TOWN <i>Rockville</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <i>13416 Glen Mill Road</i>														
14. FATHER'S NAME <i>William</i>					15. MOTHER'S MAIDEN NAME <i>Lavinia Butt</i>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>										16b. SOCIAL SECURITY NO. <i>217-36-6690</i>					17. INFORMANT <i>Ann Cavanaugh - daughter</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>180X</i> DUE TO, OR AS A CONSEQUENCE OF <i>Inanition</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>180X</i>										(b) <i>Carcinoma of ovary with metastases</i> 8 years DUE TO, OR AS A CONSEQUENCE OF										(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>171X</i>																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from <i>4-27</i> , 19 <i>68</i> , to <i>4-29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4-27</i> , 19 <i>68</i> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <i>W. G. Hall, M.D.</i>										22c. DATE SIGNED <i>4-29-68</i>														
22d. PHYSICIAN'S NAME (Type) <i>William G. Hall</i>					22e. ADDRESS <i>615 W. Montgomery Ave., Rockville, Md.</i>																													
23a. BURIAL, CREMATION, BENEFIT (Specify) <i>Burial</i>					23b. DATE <i>5/2/68</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Potomac Cemetery</i>					23d. LOCATION (City or Town) (County) (State) <i>Potomac Maryland</i>																			
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>					1331 Rockville Pike Rockville, Maryland					25a. REC'D BY REGISTRAR <i>WV 91 1968</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																			

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UNITED STATES DEPARTMENT OF AGRICULTURE

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FOR STATE  
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05798

1. DECEASED-NAME (Type or Print) <b>Ada May Chaney</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> April 14 1968			2b. HOUR <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 21 1883</b>	6. AGE (In years last birthday) <b>84 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>7</b>	IF UNDER 24 HRS. HOURS <b>7</b> MIN. <b>14</b>	2c. DATE PRONOUNCED DEAD Month <b>April</b> Day <b>17</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Asbury Methodist Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) <b>Maryland</b>		13b. COUNTY OF RESIDENCE <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>North Hammonds Ferry Road #7</b>
14. FATHER'S NAME First <b>Joseph</b> Middle <b>B</b> Last <b>oyer</b>			15. MOTHER'S MAIDEN NAME First <b>Victoria</b> Middle <b>Gaither</b> Last <b>Gaither</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>			16b. SOCIAL SECURITY NO. <b>217-32-8112 D</b>		17. INFORMANT <b>Asbury Methodist Home, Gaithersburg, Md.</b>			ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of Aortic Aneurysm.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardio Vascular Disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>441.9</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>32 days</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>0222</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John S. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>April 14, 1968</b>		
EXAMINER'S NAME (Type) <b>Dr. John Ball</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county) <b></b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 16, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Waugh Chapel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Odenton, Maryland</b>		
24. FUNERAL DIRECTOR <b>R.V. Singleton - Glen Burnie, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

05796		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05799	
Item 8 Film G399 4/26/68 kk					
1. DECEASED-NAME (Type or print) First Middle Last <i>Leroy D. Christenson</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>19</i> Year <i>68</i>		2b. HOUR <i>7 A.</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>4-23-1906</i>		6. AGE (In years last birthday) <i>61</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Utah</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.		
1d. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Dept. of Agriculture</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>—</i>	13b. COUNTY <i>—</i>	13c. CITY OR TOWN <i>Wash. D.C.</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>4545 Conn. Ave.</i>	
14. FATHER'S NAME First Middle Last <i>Warren O. Christenson</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>Hannah Ann Swire</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes</i>	16b. SOCIAL SECURITY NO. <i>yes</i>	17. INFORMANT <i>Dr. Ralph Christenson</i>	Address <i>825 Medicine Center</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepato-renal failure</i> <i>571.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cirrhosis of liver</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>5810</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/24</i> , 19 <i>68</i> , to <i>4/18</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/18/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Fred A. Gill</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <i>FRED A. GILL</i>		22e. ADDRESS <i>HORACE W. BENNETT</i>		22c. DATE SIGNED <i>4/19/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE <i>April 20 '68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Md.</i>		
23e. FUNERAL HOME <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>APR 23 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

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HEALTH DEPT

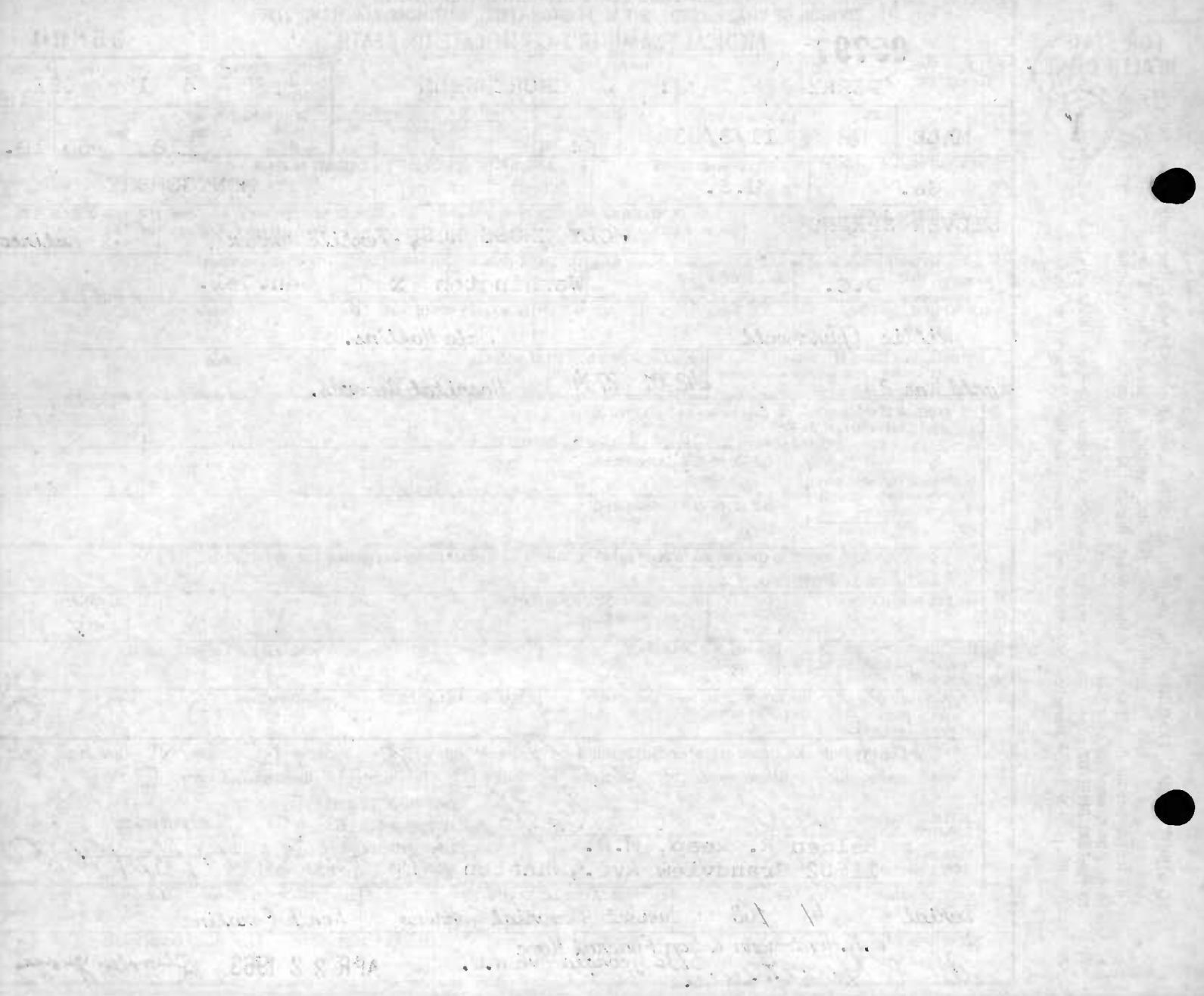
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05800

1. DECEASED-NAME (Type or Print) <b>PERRY</b>		First Middle Last <b>J. CHURCHWELL</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>18</b> Year <b>1968</b>		2b. HOUR <b>1 PM</b>	
3. SEX <b>MALE</b>	4. RACE <b>WH</b>	5. DATE OF BIRTH <b>11/3/03</b>	6. AGE (In years last birthday) <b>64 YRS.</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>18</b> Year <b>1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>Ga.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Textile Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Gen. Del.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>Willie Churchwell</b>		First Middle Last		15. MOTHER'S MAIDEN NAME <b>Mela Hollins.</b>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>World War 2</b>		16b. SOCIAL SECURITY NO. <b>242 01 2734</b>		17. INFORMANT <b>Hospital Records.</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute intracerebral Hemorrhage due to</b> <b>4/20</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>443X</b> (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Bilateral Pneumonitis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>Belden R. Reap, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>4/18/1968</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/ 168</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>North Carolina</b>	
24. FUNERAL DIRECTOR <b>W. K. Huntemann &amp; Son Funeral Home</b>				25a. REC'D BY REGISTRAR <b>APR 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PM3. Page 5 may be retained for your files."

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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V. 1/68

25a. REC'D BY REGISTRAR  
DATE **APR 26 1968**



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

05802

1. DECEASED-NAME (Type or print) <b>ARCHIE Ball CLOTHIER</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>27</b> Year <b>1968</b>		2b. HOUR <b>1:10</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>10/20/94 1893</b>	6. AGE (In years last birthday) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>VA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Police</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Don't</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>725 Denmon Ave</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>S.</b> Last <b>Clothier</b>	15. MOTHER'S MAIDEN NAME First <b>Inea</b> Middle <b>Millwa</b> Last <b>Stephenson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>	16b. SOCIAL SECURITY NO. <b>577-42-9042</b>	17. INFORMANT Address <b>Mr. David S. Clothier 740 Easley St. S.S.,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> <b>441.2</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>451X</b> (b) <b>Thrombosis-Arteriosclerosis-Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>miss.</b> <b>hrs.</b> <b>years.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>Diabetes Mellitus</b>					
19a. DATE OF OPERATION <b>7/26/68</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Arteriosclerosis-impulse</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 28, 1965</b> , to <b>4/27, 1968</b> , that (I) (we) lost saw the deceased alive on <b>4/26, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE <b>Harold W. Draper M.D.</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>HAROLD W. DRAPER</b>		22c. DATE SIGNED <b>4/27/68</b>			
22e. ADDRESS <b>9801 GEORGE A AVE, SILVER SPRING</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 30, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Beallsville, Montgomery Md.</b>		
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey Inc.</b>		ADDRESS <b>8434 Ga. Ave. S.S., Md.</b>	25a. REC'D BY REGISTRAR <b>MAY 6 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Yunge</b>	

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DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
STATE OF NEW YORK  
NEW YORK  
1912

Birth Record

Name: [illegible]  
Sex: [illegible]  
Date of Birth: [illegible]  
Place of Birth: [illegible]  
Parents: [illegible]  
Occupation: [illegible]  
Religion: [illegible]  
Marital Status: [illegible]  
Education: [illegible]  
Social Status: [illegible]  
Other: [illegible]

Signature: [illegible]  
Date: [illegible]

CERTIFICATE OF DEATH

05799

05803

1. DECEASED-NAME (Type or print) <b>Nellie Fraaces CODY</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>6</b> Year <b>68</b>			2b. HOUR <b>2300</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>7-6-1883</b>		6. AGE (In years last birthday) <b>84</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Kensington, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kensington Gardens San H. W.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STREET <b>5608 New Hampshire Ave. D.C.</b>		13b. CITY OR TOWN <b>Wash.</b>		13c. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3608 New Hampshire Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Wilhelm - Schlosser</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>GEORGINA AVERY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>577-189647</b>		17. INFORMANT Address <b>Sil. Springs Rd.</b> <b>Helen Smith, 1900 Lyttonsville Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ser. Gyr</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4500</b>							
19a. DATE OF OPERATION <b>Phone</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1968</b> to <b>Apr. 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>Apr. 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Lynwood Hedges M.D.</b>				22c. DATE SIGNED <b>4/6/68</b>		22e. ADDRESS <b>6940 Piney Branch Rd. Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VA.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS, 5130 WIS. AVE, N.W., WASHINGTON, D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>CLYTIE BOGLE</b>		First Middle Lost		2a. DATE OF DEATH Month Day Year <b>April 29, 1968</b>		2b. HOUR <b>1:15</b> M	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>Nov. 16, 1889</b>		6. AGE (In years last birthday) <b>78</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Miss.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5614 Wilson Lane</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>5614 Wilson Lane</b>		14. FATHER'S NAME First Middle Lost <b>Absy Caswell Bogle</b>		15. MOTHER'S MAIDEN NAME First Middle Lost <b>Lelie Burch</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>579-32-0712</b>		17. INFORMANT <b>Mrs. Lish Whitson</b> Address <b>Same as Item 13.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> <b>431.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>331X</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 11, 1965</b> to <b>April 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William T. Gill, Jr.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-29-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM T. GILL, JR.</b>		22e. ADDRESS <b>1746 K Street, N. W. Washington, D. C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>San Diego, California</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAY 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Georgia		May	Connell	April	Month 17	Day 1968	M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		June 30, 1887		80 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Washington, D.C.		U.S.A.		Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		University Nursing Home		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Montgomery		Kensington				1111 Midvale Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Edward		E.	Hopkins		Sarah		A.	Thecker	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		1111 Midvale Road		Kensington, Maryland	
No		yes							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Carcinoma of Throat</u>								2 years	
1519 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
151X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>July 31, 1966</u> , to <u>April 12, 1968</u> ; that (I) (we) last saw the deceased alive on <u>April 12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William Brann</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/17/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>					22e. ADDRESS <u>6056 Central Ave, Capital Hgt Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 22, 1968		Glenwood Cemetery		Washington, D.C.			
24. FUNERAL DIRECTOR <u>C. Glen Carter 8434 Georgia Ave.</u>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>Barner E. Pumphrey, Inc. Silver Spring, Md.</u>					DATE <u>APR 22 1968</u>		<u>J. Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05802

05806

1. DECEASED-NAME (Type or print) <i>Sam</i> First Middle Last <i>Cooper</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>25</i> Year <i>68</i>		2b. HOUR <i>8:30</i> PM
3. SEX <i>male</i>	4. RACE <i>negro</i>	5. DATE OF BIRTH <i>2/22/05</i>		6. AGE (In years last birthday) <i>63</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Member</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Private</i>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. CITY OR TOWN <i>Rockville</i>	
13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Route 28</i>	
14. FATHER'S NAME First <i>Joseph</i> Middle <i>Cooper</i> Last <i>Cooper</i>			15. MOTHER'S MAIDEN NAME First <i>Anna Rebecca</i> Middle <i>Leffler</i> Last <i>Leffler</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Dorothy M. Cooper</i> Address <i>Rockville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, recent, diffuse, rt. &amp; lt. ventricle and interventricular septum</i> 4109 DUE TO, OR AS A CONSEQUENCE OF <i>coronary arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL, 1968</i> , to <i>4-25, 1968</i> , that (I) (we) last saw the deceased alive on <i>4-15-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Stephen W. DeJeter</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <i>STEPHEN W. DEJETER, MD</i>		22c. DATE SIGNED <i>4/26/68</i>			
22e. ADDRESS <i>6719 WILSON LA, BETHESDA, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-30-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park</i>	
23d. LOCATION (City or Town) (County) (State) <i>Rockville, Md. Montgo</i>					
24. FUNERAL DIRECTOR <i>Bernard R. Anderson</i>		ADDRESS <i>Rockville, Md</i>		25a. REC'D BY REGISTRY <i>1968</i>	
				25b. REGISTRY SIGNATURE <i>James Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Placed in the hands of the coroner for the body 4/15/68 9:30 AM

05803		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05807					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P M			
EUGENE W COUGHLIN						April 15 1968		6 P			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Male		White		12-21-1892		75 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Missouri		U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Kensington			Kensington Gardens Spaulding Assoc. of American R.R.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D.C.			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3132 Birch St N.W.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Daniel					Coughlin	Hinkley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable CVA 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7201 (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) GSHD.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) Coronary insufficiency, Left Ventricular Strain											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A		
N/A			N/A								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) N/A					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) N/A			21f. LOCATION Street or R.F.D. No. City or Town County State N/A					
22a. I certify that (X) (this hospital) attended the deceased from 3/26, 1968, to 4/15, 1968, that (X) (we) last saw the deceased alive on 4/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald D. Haut MD			DEGREE			FOR FRANCIS J. Murray, MD ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4/15/68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Donald D. Haut			2141 K St N.W. Suite 608 Washington D.C. 20037								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			4-18-68		Fort Lincoln		Wash., D.C.				
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W., Wash., D.C., 20016						25a. REC'D BY REGISTRAR DATE APR 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05804

05808

1. DECEASED-NAME (Type or print) <b>Ormond</b>			First <b>L.</b>			Middle <b>COX</b>			Last			2a. DATE OF DEATH <b>April</b> Month <b>16</b> Day Year <b>68</b>			2b. HOUR <b>215A</b> M		
3. SEX <b>Male</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>Oct. 16, 1883</b>			6. AGE (in years last birthday) <b>84</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>						Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda,</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U. S. Navy</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Chevy Chase</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>107 Grafton Street,</b>					
14. FATHER'S NAME <b>Samuel Gregory Cox</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Marth Jane Herron</b>			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year and grades of service) <b>Yes 1905-46</b>			16b. SOCIAL SECURITY NO. <b>578 46 8942</b>			17. INFORMANT <b>Mrs. Jane C. Miner, 107 Grafton St. Chevy Chase, Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF <b>advanced, severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } <b>lost 4227</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Bronchial pneumonia, confluent, left lower lobe lung</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>Apr. 14</b> , 19 <b>68</b> , to <b>Apr. 16</b> , 19 <b>68</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>Apr. 16</b> , 19 <b>68</b> , and that in <del>(our)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(X)</del> (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>C. M. HERMAN</b>			DEGREE <b>M. D.</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>Apr. 16, 1968</b>								
22d. PHYSICIAN'S NAME (Type) <b>C. M. HERMAN</b>						22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			23b. DATE <b>4-20-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>								
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>			Address <b>7557 Wisconsin Ave., Bethesda, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>APR 22 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

02804

02804

Name	Position	Age	Rank	No.
Crisp	Sergeant	24	Private	1
L. J. Smith	Private	21	Private	2
J. W. Jones	Private	22	Private	3
W. H. Brown	Private	23	Private	4
J. E. Davis	Private	25	Private	5
R. L. Wilson	Private	26	Private	6
T. M. Moore	Private	27	Private	7
S. K. Taylor	Private	28	Private	8
D. N. White	Private	29	Private	9
H. G. Black	Private	30	Private	10
J. F. Green	Private	31	Private	11
K. L. Hall	Private	32	Private	12
L. M. King	Private	33	Private	13
M. P. Lee	Private	34	Private	14
N. Q. Reed	Private	35	Private	15
O. R. Scott	Private	36	Private	16
P. S. Turner	Private	37	Private	17

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05805 Item 23b Film G399 4/26/68 kk CERTIFICATE OF DEATH 05809											
1. DECEASED-NAME (Type or print) First Middle Last <b>MAJORIE C COZINE</b>						2a. DATE OF DEATH Month Day Year <b>APRIL 20 1968</b>			2b. HOUR <b>1:20PM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>2 FEBRUARY, 1894</b>		6. AGE (In years lost birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>VA.</b>		13b. COUNTY <b>ARLINGTON</b>		13c. CITY OR TOWN <b>ARLINGTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3079 S. BUCCANNAN ST.</b>			
14. FATHER'S NAME First Middle Last <b>John Franklin Chapin</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Minnie McCann</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MR. PAUL B. COZINE 3079 S. BUCCANNAN ST.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullous Emphysema with pneumothorax, left</b> <b>492X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5271</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4 APRIL, 1968</b> , to <b>20 APRIL, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>20 APRIL, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <i>S. Frank DoVI</i>				DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>23 April 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>S. Frank DOVI, M. D</b>				22e. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>Apr. 23, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>					
24. FUNERAL DIRECTOR <b>Everly-Wheatley Funeral Home</b> <b>Alexandria, Virginia</b>				25a. REC'D BY REGISTRAR <b>APR 24 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

03807

03807

STATE OF TEXAS  
COUNTY OF DALLAS

Know all men by these presents, that \_\_\_\_\_ of the County of \_\_\_\_\_ State of \_\_\_\_\_

do hereby certify that \_\_\_\_\_ of the County of \_\_\_\_\_ State of \_\_\_\_\_

is the owner of the following described land, to-wit:

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05806

05810

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First Middle Last <i>William Edward Crawford</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year <i>April 29 1968</i>			2b. HOUR <i>4:35 PM</i>			
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>1/12/02</i>		6. AGE (In years last birthday) YRS MONTHS DAYS <i>66 1 1</i>		7c. DATE PRONOUNCED DEAD Month Day Year <i>April 24 1968</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md.
10. CITY OR TOWN OF DEATH <i>Bethesda, Maryland</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Lab &amp; Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Lab Assistant</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>V. I. H.</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Mont. Co.</i>			13c. CITY OR TOWN <i>Rockville</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last <i>Charles F. Crawford</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Laura Yingling</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>219-14-8340</i>
17. INFORMANT <i>(son) Wayne Crawford</i>			ADDRESS <i>same as above</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Cardio Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>									
19a. DATE OF OPERATION <i>4/20/68</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John M. Bell</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) <i>7936 Old Georgetown Road Rockville</i>			ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <i>4/24/68</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/27/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Frederick Montgomery Md.</i>		
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



1.000

## CERTIFICATE OF DEATH

05807

05811

1. DECEASED-NAME (Type or print) <b>EARLAISE CRUTCHFIELD</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>6</b> Year <b>68</b>			2b. HOUR <b>9:58 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>9/7/68</b>		6. AGE (In years last birthday) <b>57</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>8821 Brookville RD.</b>		14. FATHER'S NAME First <b>FOREST</b> Middle <b>WEBSTER</b> Last <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>UNKNOWN</b> Last <b>UNKNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>RAYMOND CRUTCHFIELD - Same</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OSTEOMYELITIS OF PELVIS with</b> <b>7202</b> DUE TO, OR AS A CONSEQUENCE OF <b>CELLULITIS + ABSCESS VULVA +</b> <b>RIGHT THIGH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>7302</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS; CIRRHOSIS OF LIVER</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/16</b> 19 <b>68</b> , to <b>4/6</b> 19 <b>68</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>4/6</b> 19 <b>68</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <b>David Goldenberg MD</b>		22c. DATE SIGNED <b>4/7/68</b>		22d. PHYSICIAN'S NAME (Type) <b>DAVID GOLDENBERG MD</b>		22e. ADDRESS <b>9801 CEDARHART, SILVER SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>4-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pilgrim Church Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Montg. Md.</b>	
24. FUNERAL DIRECTOR <b>Robert L. Davidson</b>		24a. REC'D BY REGISTRAR <b>APR 17 1968</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1981

CERTIFICATE OF DEATH

05801



DEPARTMENT OF HEALTH  
COUNTY OF ALBERTA  
HEALTH UNIT

DIABETES MELLITUS; CIRRHOSIS OF LIVER

X

DATE OF DEATH 4/18/81

DAVID WOODWARD MD  
4/18/81

APR 17 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Thomas Grayson Dade			2a. DATE OF DEATH Month Day Year April 13 1968			2b. HOUR M 6:45			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 6-11-98		6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. <del>NEVER MARRIED</del> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Insurance Co.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Wash.		13c. CITY OR TOWN Wash.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3024 Porter ST. N.W.	
14. FATHER'S NAME First Middle Last Grayson Dade			15. MOTHER'S MAIDEN NAME First Middle Last Violet Ash						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) Yes. Marines		16b. SOCIAL SECURITY NO. 57748-4006		17. INFORMANT Cousin A. Mrs. A. Hickey		3516 Address Penny Meade P. Washington, D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 ARTERIO-SCLEROTIC CV. Dis DUE TO, OR AS A CONSEQUENCE OF with uremia (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes 6 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1963, to APR 13, 1968, that (I) (we) last saw the deceased alive on APR 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DeWitt E. DeLawter				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED APR 13, 1968			
22d. PHYSICIAN'S NAME (Type) DeWitt E. DeLawter MD.				22e. ADDRESS 3848 Porter St. NW: Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-23-68		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City or Town) (County) (State) Beallsville, Maryland			
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

00630

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
John Edward Davis			John	Edward	Davis	April 10 68			1:15 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Caucasian		March 27, 1885		83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		8209 Flower Avenue		Ret. D.C. Transit Op.		D.C. Transit			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Takoma Pk				8209 Flower Avenue	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John			J		Davis	Josephine			Spalding
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			578-10-7421		Joseph P. Spalding 1620 Drexel St., J.P.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon</u> <u>1539</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 mo.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>1539</u> <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
July '66		Obstruction							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
				N/A					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (b) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>4-10</u> , 19 <u>68</u> , that <u>we</u> (we) last saw the deceased alive on <u>4-9</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. U. Shilling MD</u>					22c. DATE SIGNED <u>4-10-68</u>				
22d. PHYSICIAN'S NAME (Type) <u>C. U. Shilling</u>					22e. ADDRESS <u>7601 Little River InPk, Annandale, Va.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 12, 1968		Fert. Lincoln Cemetery		Prince George's Maryland			
24. FUNERAL DIRECTOR <u>G. Glen Carter</u>					25a. REC'D BY REGISTRAR <u>Glen Carter</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
Warner E. Pumphrey, Inc., 8434 Ga., Ave., S.E.					DATE <u>APR 15 1968</u>				

90330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Lost			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Marie			C. Davis			April 30 1968		1255		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		Cauc.		Aug. 11, 1923		44 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York		U. S. A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Bethesda Naval Hospital			Homemaker		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George		Bowie				Belair-Bowie, Maryland 3007 Stonybrook Drive	
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost							
Thomas Joseph O'Brien			Marie St. Claire							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes			WW II 089 16 7629		Mr. Doyle L. Davis 3007 Stonybrook Drive					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PRIMARY ADENOCARCINOMA, LEFT KIDNEY</u> <u>189.0</u> DUE TO, OR AS A CONSEQUENCE OF WITH <u>WIDESPREAD METASTASES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>180X</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 28</u> , 19 <u>68</u> , to <u>April 30</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>April 30</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>H. M. Rivas</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED May 1, 1968			
22d. PHYSICIAN'S NAME (Type) H. M. RIVAS, CDR, MC, USN					22e. ADDRESS Bethesda Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/3/68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Ceme.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia				
24. FUNERAL DIRECTOR Francis Gasch's Sons 4739		24b. ADDRESS Hyattsville, Maryland		24c. RECEIVED BY REGISTRAR MAY 3 1968		24d. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>				

17



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)  
30M REV. 1-66

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
05811									
05815									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR P
Mary				Loretta	Davis	4 Month 18 Day 1968			11:30 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
female		white		3/23/86		82 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney,			Montgomery Gen. Hospital			housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince Geo.		Berwyn Hghts		YES <input type="checkbox"/> NO <input type="checkbox"/>		8500 Edmonston avenue
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Charles			T.	Brosius		Laura			Trundle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
no					Montgomery records: General Hospital, Olney, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-Cranial Hemorrhage</u> <u>431.9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebro-Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis, Genl.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>331X</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>Years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>H.C.U.D.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1949</u> , 19 <u>  </u> , to <u>Apr. 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>Apr. 28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jack Schumacher</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-19-68</u>		
22d. PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.					22e. ADDRESS 205 Russel st., Gaithersburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>4/22/68</u>		<u>Monacay</u>		<u>Beallville Montg Md</u>			
24. FUNERAL DIRECTOR <u>Hilton Funeral Home Barneville</u>					ADDRESS <u>Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



21322

OFFICE OF DEATH

100-13-1000



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05812

05816

1. DECEASED-NAME (Type or Print) <b>MICHEL PETER DeCOCKER</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>4</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>10:10 A</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>2-21-09</b>	6. AGE (In years last birthday) <b>59</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>21</b> Year <b>1968</b>			
7a. BIRTHPLACE (State or foreign country) <b>BELGIUM</b>		7b. CITIZEN OF WHAT COUNTRY? <b>BELGIUM</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San. &amp; Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Houseman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>8414 Dennybrook Dr.</b>	
14. FATHER'S NAME First <b>MICHEL</b> Middle <b>PIETER</b> Last <b>DeCOCKER</b>			15. MOTHER'S MAIDEN NAME First <b>ROSA</b> Middle <b>WILLIAMS</b> Last <b>WILLIAMS</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <b>No</b> , or unknown) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>578-66-9253</b>			17. INFORMANT <b>GEORGIA DeCOCKER</b>			18. ADDRESS <b>8414 Dennybrook Dr. Ch. Ch. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4129</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>8414 Dennybrook Dr.</b>		City or Town <b>Silver Spring</b>		County <b>MONTGOMERY</b> State <b>Md.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Belden R. Peap</b>		EXAMINER'S NAME (Type) <b>BELDEIN R. PEAP, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 27, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) <b>Silver Spring, Maryland</b>		23e. COUNTY <b>MONTGOMERY</b> STATE <b>Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 26 1968</b>				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

91320

72-50-54-152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05812		05817										
1. DECEASED-NAME (Type or print)		First ANNIE	Middle LUCIA	Last DE LISIO	2a. DATE OF DEATH Month APRIL		Day 12	Year 1968	2b. HOUR 6:15 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 7-26-92		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS		OAYS	IF UNDER 24 HRS. HOURS	MIN.
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY COUNTY Mo.						
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SANITARIUM & HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 902 LINWOOD ST.				
14. FATHER'S NAME First Leonardo		Middle Capossella		Last LUCIA		15. MOTHER'S MAIDEN NAME First CESTONE		Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 578-46-8880		17. INFORMANT Address Information Record - Hospital Records								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2001 DUE TO, OR AS A CONSEQUENCE OF Lymphosarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2001												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from June 6, 1968, to June 12, 1968, that (I) (we) last saw the deceased alive on June 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Gene U. Cohen M.D.		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED April 12, 1968		
22d. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.		22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MARYLAND.										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 17 APRIL 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN MAUSOLEUM		23d. LOCATION (City or Town) BLADENSBURG MD.		(County)		(State)		
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME INC. 7400 GEORGETOWN AVE. N.W.		ADDRESS DC 20012		25a. REC'D BY REGISTRAR DATE APR 16 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...						

05339

CHICKEN HEAD

05317



05814

05818

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
William Ross DELLETT						Month	Day	Year	12 <sup>00</sup> A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
male		white		12-10-92		72 YRS.		MONTHS	DAYS	HOURS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Wash. DC		U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
BETHESDA		Suburban		Retired-Distributor-		Wash. News Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			Montgomery		CHEVY CHASE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4603 Norwood PL	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Robert Ould Dellett			Jeanette			Luss				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or military service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes Army			577-09-6760A		Son Robert Dellett Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) acute coronary occlusion									36 hours	
DUE TO, OR AS A CONSEQUENCE OF										
(b) Anterior wall Myocardial Infarction									3 years	
DUE TO, OR AS A CONSEQUENCE OF										
(c) with Hypertension										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work										
22a. I certify that (I) (this hospital) attended the deceased from June, 1965, to 4-23, 1968, that (I) (we) last saw the deceased alive on 4-23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
P.P. Andrews MD							<input checked="" type="checkbox"/>		4-24-68	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
P.P. ANDREWS					4201 Fossenden St N.W. Washington					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		4-26-68		Glenwood Cemetery			Washington, D. C.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY, Bethesda, Maryland							DATE		APR 29 1968 Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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OFFICE OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1 (1)  
304 REV. 1-68

05815

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05819

1. DECEASED-NAME (Type or print) <u>Filomeno</u> First Middle Lost			2a. DATE OF DEATH Month Day Year <u>April 27 1968</u>			2b. HOUR <u>4:45</u> AM						
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>July 20, 1896</u>		6. AGE (In years last birthday) <u>71</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <u>Italy</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.						
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>House Wife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>12104 Selfridge Rd.</u>				
14. FATHER'S NAME First Middle Lost <u>Francesco Candore</u>			15. MOTHER'S MAIDEN NAME First Middle Lost <u>Angelina Roseamelia</u>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)						
16b. SOCIAL SECURITY NO. <u>578 62 2919</u>			17. INFORMANT Address <u>Maria Peterson, 11703 Ashley Drive, Rockville Md.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>2509</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } <u>UNKNOWN</u> } <u>NO. OF YEARS</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 HOURS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>260X</u> <u>OBESITY</u>												
19a. DATE OF OPERATION <u>—</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>—</u>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>—</u>			21f. LOCATION Street or R.F.D. No. City or Town County State <u>—</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u> , 19 <u>68</u> , to <u>APRIL</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>APRIL 27</u> , 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.												
22b. SIGNATURE <u>Michael S. Madeloff M.D.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/27/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>MICHAEL S. MADELOFF</u>		22e. ADDRESS <u>10620 GEORGIA AVE SILVER SPRING MD</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/30/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Pr Geo Co Md.</u>					
24. FUNERAL DIRECTOR <u>W.K. Huntmann &amp; Son</u>		ADDRESS <u>3732 Georgia Ave N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						

CHIEF OF POLICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <u>Mabel Ethel Dobeck</u>			2a. DATE OF DEATH <u>April</u> Month <u>3</u> Day <u>1968</u> Year			2b. HOUR <u>10:25</u> P M			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>7/30/183</u>		6. AGE (In years last birthday) <u>84</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.			
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanitarium Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Unknown-retired</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>401 Lanark Way</u>	
14. FATHER'S NAME First <u>Charles M.</u> Middle <u>Shaw</u> Last <u>Shaw</u>			15. MOTHER'S MAIDEN NAME First <u>Alma</u> Middle <u>(Unknown)</u> Last <u>Irish</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>		16b. SOCIAL SECURITY NO. <u>198-05-9002A</u>		17. INFORMANT <u>Washington Sanitarium Hospital record</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma left lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days - 6 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>163X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> , 19 <u>57</u> , to <u>4-3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Norman G. Shoemaker, M.D.</u>				22c. DATE SIGNED <u>4/3/68</u>		22d. PHYSICIAN'S NAME (Type) <u>Norman G. Shoemaker, M.D.</u>			
22e. ADDRESS <u>811 Dale Drive, Silver Spring, MD 20916</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/6/68</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md</u>			
24. FUNERAL DIRECTOR <u>SH Hines Co</u>				25a. REC'D BY REGISTRAR <u>2901 148 NW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 8 - 1968</u>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05817

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05821

1. DECEASED-NAME (Type or Print)			First <b>HARRY</b>	Middle <b>LEON</b>	Last <b>DOWNEY</b>	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>4 16 1968</b>			2b. HOUR <b>12A</b>
3. SEX <b>MALE</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>10-24-1898</b>	6. AGE (In years last birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>APRIL 16 1968</b>			2d. HOUR <b>3</b>
7a. BIRTHPLACE (State or foreign country) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			Md.
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>BETHESDA</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>5516 Sonoma Rd</b>		
14. FATHER'S NAME First Middle Last <b>Harry Downey</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Leona Quinn</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Wife - Myrtle J. Downey</b>			ADDRESS <b>(see item #13)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cardiovascular Disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b> <b>4129</b> <b>years.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4301</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John G. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>April 16, 1968</b>			
EXAMINER'S NAME (Type) <b>John G. Ball</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>Mont. Co. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-19-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, G.G.Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisconsin Ave. N.W., Wash. D.C.</b>				25a. REC'D BY REGISTRAR <b>APR 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

51329



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>05818</div> <div>CERTIFICATE OF DEATH</div> <div>05822</div>									
1. DECEASED-NAME (Type or print) <b>Baby</b> <b>Boy</b> <b>DuBois</b>						2a. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1968</b>		2b. HOUR a <b>10:20</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 9, 1968</b>		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash., San &amp; Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>910 5th St.</b>	
14. FATHER'S NAME First <b>Ronald</b> Middle <b>K.</b> Last <b>DuBois</b>				15. MOTHER'S MAIDEN NAME First <b>Janice</b> Middle <b>Lee</b> Last <b>Keeper</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Janice DuBois 910 5th St., Laurel, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>777X</b> <b>Prenatal</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>776X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Charles Judge</b> M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>5-7-68</b>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS <b>9801 George Washington</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>4-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash., San &amp; Hospital</b>		23d. LOCATION (City or Town) (County) (State) <b>Takoma Park, Mont. Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>J.D. Ruffcorn, Takoma Park, Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>MAY 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

21350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05819

05823

1. DECEASED-NAME (Type or print) <u>GRAZIELLA H Esquerre</u> Middle Last		2a. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1968</u>		2b. HOUR <u>10:15</u> M
3. SEX <u>Female</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH <u>9/21/1881</u>		6. AGE (In years last birthday) <u>86</u> YRS.
7a. BIRTHPLACE (State or foreign country) <u>Cuba</u>		7b. CITIZEN OF WHAT COUNTRY? <u>Cuba</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>Mont.</u>		Md.		
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>Mont</u>	13c. CITY OR TOWN <u>Silver Spring</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER <u>13003 Middlebrook Lane</u>				
14. FATHER'S NAME First <u>Andres</u> Middle <u>Beracierto</u> Last <u>Beracierto</u>		15. MOTHER'S MAIDEN NAME First <u>Regina</u> Middle <u>Rezerre</u> Last <u>Rezerre</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <u>150-26-096810</u>		17. INFORMANT Address <u>Same as above</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>410.9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary art. occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>18 day</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>420.1 Diabetes Mellitus - Right base pneumonia</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2</u> , 19 <u>68</u> , to <u>4-16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Benito H. Prats MD</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>4-16-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Benito H. Prats</u>		22e. ADDRESS <u>7507 Arlington Rd. Bethesda, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4-19-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	23d. LOCATION (City or Town) (County) (State) <u>WHEATON MD</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>		ADDRESS <u>Silver Spring Md</u>	25a. REC'D BY REGISTRAR DATE <u>APR 18 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Plimmar Judge</u>

21339

2089 COTTON FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05820		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05824	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Lillian M. Etter</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>14</i> Year <i>1968</i>			2b. HOUR <i>5:30</i> M	
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>7/1/1912</i>		6. AGE (In years last birthday) <i>55</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Comp. Machine Embroidery Sew</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>22 Walker Ave</i>		14. FATHER'S NAME First <i>Preston</i> Middle <i>Strat</i> Last <i>Unknown</i>		15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Husband - Omar Etter</i>		Address <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Toxemia</i> <i>180X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>azotemia, myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>urinary shutdown</i> <i>171X</i>						<i>4-10-68</i> <i>4-11-68</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>postoperative circulatory failure</i>							
19a. DATE OF OPERATION <i>3-26-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Recurrent Cancer</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/11</i> , 19 <i>68</i> , to <i>4/14</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4-14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22b. SIGNATURE <i>John O. Robbins M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED <i>4/14/68</i>		22d. PHYSICIAN'S NAME (Type) <i>JOHN O. ROBBENS</i>		22e. ADDRESS <i>10400 Conn. Ave. Kensington, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Blandensburg, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>APR 17 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

08834

UNITED STATES OF AMERICA

08833



NOTICE

UNITED STATES OF AMERICA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Closed with medical examiner's stamp

05821												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												05825			
1. DECEASED-NAME (Type or print) First Middle Last NORA FALLON												2a. DATE OF DEATH Month Day Year April 10 1968												2b. HOUR 30 8:30 M			
3. SEX Female				4. RACE White				5. DATE OF BIRTH April 4, 1888				6. AGE (In years last birthday) 80 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) Ireland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.															
10. CITY OR TOWN OF DEATH Silver Springs				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairland Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York				13b. COUNTY Queens				13c. CITY OR TOWN New York				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 439 Beach 125th Street											
14. FATHER'S NAME Daniel Mullane				15. MOTHER'S MAIDEN NAME Catherine Fitzgerald				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)												16b. SOCIAL SECURITY NO. 118-20-2007 A				17. INFORMANT Mr. Martin Fallon 14608 Pebblestone Dr. S.S.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4129 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 5/26/1967, to 4-10-1968, that (I) (we) lost saw the deceased alive on 3-31-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE Boris Rabkin				DEGREE BORIS RABKIN, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4-10-68															
22d. PHYSICIAN'S NAME (Type) BORIS RABKIN, M.D.				22e. ADDRESS 1019 University Blvd East																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE April 13, 1968				23c. NAME OF CEMETERY OR CREMATORY St. Raymond Cemetery				23d. LOCATION (City or Town) (County) (State) Bk Bronx New York															
24. FUNERAL DIRECTOR Glen Carter Warner E. Pumphrey Inc.				ADDRESS 8434 Georgia Ave. S.S.				25a. REC'D BY REGISTRAR DATE APR 15 1968				25b. REGISTRAR'S SIGNATURE Charles J. Jones															



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Anna Middle Marie Last Femia			2a. DATE OF DEATH Month April Day 2 Year 1968		2b. HOUR A 7:15 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 22 August 1939		6. AGE (In years last birthday) 28 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New Jersey	13b. COUNTY --	13c. CITY OR TOWN Bayonne	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 160 West 52nd Street	
14. FATHER'S NAME First Joseph Middle Velluzzi Last		15. MOTHER'S MAIDEN NAME First Alma Middle Polhemus Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 154-30-1594	17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Md. 20014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 7341 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>456x</u> (b) <u>Systemic Lupus Erythematosus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days unknown months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension; Treated Tuberculosis; Recurrent Pulmonary Emboli</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <u>October 4, 1967</u> , to <u>April 2, 1968</u> , that (X) (we) last saw the deceased alive on <u>April 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <u>James T. Willerson M.D.</u>		22c. DATE SIGNED 2 April 1968	22d. PHYSICIAN'S NAME (Type) James T. Willerson, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>NO</u>		23b. DATE 5 April 1968	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <u>BAYONNE, N.J.</u>
24. FUNERAL DIRECTOR <u>RINARDI FUNERAL HOME INC. 7400 GEORGIA AVE. N.W.</u>		25a. REC'D BY REGISTRAR DATE APR 4 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

05829

CERTIFICATE OF DEATH

05829

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Cause of Death		Time of Death	
Signature of Physician		Signature of Registrar	
Signature of Family		Signature of Burial	
Signature of Minister		Signature of Cemetery	
Signature of Coroner		Signature of Undertaker	
Signature of Medical Examiner		Signature of Health Officer	
Signature of Police		Signature of Fire Department	
Signature of Fire Department		Signature of Police	
Signature of Health Officer		Signature of Medical Examiner	
Signature of Coroner		Signature of Minister	
Signature of Burial		Signature of Family	
Signature of Registrar		Signature of Physician	
Signature of Cause of Death		Signature of Place of Birth	
Signature of Date of Death		Signature of Name of Deceased	



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VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>ARNOLFO</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>4-4-68</b>			2b. HOUR A M <b>10:05</b>					
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>7-15-1887</b>			6. AGE (In years last birthday) <b>80</b> YRS.					
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>KENSINGTON GARDENS SANIT.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PLASTERER</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>3129 Oliver St. N.W. Washington D.C.</b>			13b. COUNTY <b>D.C.</b>			13c. CITY OR TOWN <b>Washington D.C.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>3129 Oliver St N.W.</b>		
14. FATHER'S NAME <b>MARIANO</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Fioravanti</b>			First Middle Last <b>Z</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>225-05-2016</b>			17. INFORMANT <b>MRS. MAFFESOLI-3129 Oliver St. N.W.</b>			Address <b>Wash. D.C.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertatic pneumonia</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4200</b> (b) <b>Atherosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Early arthritis, severe with bed sores</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>about 20 yrs</b> <b>many years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes, &amp; Chronic prostatitis with urethral stricture</b>														
19a. DATE OF OPERATION <b>12/14/67</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>stricture; urethral</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> , 19 <b>67</b> , to <b>4/4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>3/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Paul A. Mangano, M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>4/4/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Paul A. Mangano, M.D.</b>						22e. ADDRESS <b>3021 M St. N.W.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/8/68</b>			23b. DATE <b>4/8/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>			23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG MD.</b>					
24. FUNERAL DIRECTOR <b>HANLON FUNERAL HOME - WASH. D. C.</b>						25a. REC'D BY REGISTRAR DATE <b>APR 15 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION



SS&P



05824

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05828

1. DECEASED-NAME (Type or print) <b>Cynthia Ann GARY</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>68</b>			2b. HOUR <b>2:45</b> PM	
3. SEX <b>Female</b>		4. RACE <b>Negroid</b>		5. DATE OF BIRTH <b>January 24, 1967</b>		6. AGE (In years last birthday) <b>1</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George</b>		13c. CITY OR TOWN <b>Seat Pleasant</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME First <b>James Arthur</b> Middle <b>Gary</b>		15. MOTHER'S MAIDEN NAME First <b>Beverly Ann</b> Middle <b>Wilson</b>		17. INFORMANT <b>Pleasant</b> Address <b>Md.</b> <b>James Arthur Gary, 7303 Weston Ave. Seat</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>283.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>292.2</b> (b) <b>Autoimmune hemolytic anemia</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <b>Bilateral bronchopneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 13, 1968</b> , to <b>April 13, 1968</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 13, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>G. P. Swartz</b>		22c. DATE SIGNED <b>April 15, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>G. P. Swartz, M. D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-18-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>John T. Rhines Funeral Home</b> <b>3015 12th St. N.E., Washington, D. C.</b>				25a. REC'D BY REGISTRAR <b>APR 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <b>JEANINE MINNA JOHNSTON</b>			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4-2 1968			2b. HOUR <b>6:30</b> M.		
3. SEX <b>FE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>3/28/1934</b>		6. AGE (in years and birthday) <b>34</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4140 Great Oak Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Rockville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>4140 Great Oak Rd.</b>			14. FATHER'S NAME First Middle Last <b>Walter D. Johnston</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Thelma M. Jameson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Henry M. Gay,</b>			ADDRESS <b>see # 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>955x Gunshot wound in head, apparently self-inflicted</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Depression</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>976x</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>976x Depression</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>6:45 A.M. 4-3 1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) <b>Deceased, depressed, shot self in head</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>HOME</b>			21f. LOCATION Street or R.F.D. No. City or town County State <b>4140 Great Oak Rd. Rockville Montgomery Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Belden R. Reap</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>			ADDRESS (Street, City, Town, County) <b>4140 Great Oak Rd. Rockville, Md.</b>			22b. DATE SIGNED <b>4/4/2/68</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>4/5/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven</b>			23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>		
24. FUNERAL DIRECTOR <b>Jos. Gawler's</b>			ADDRESS <b>5130 Wisconsin Av., Wash.D.C.</b>			25a. REC'D BY REGISTRAR <b>APR 5 - 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

9882

WORLD EXHIBITION, CHICAGO, 1893

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WORLD EXHIBITION, CHICAGO, 1893

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WORLD EXHIBITION, CHICAGO, 1893

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05826										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05830									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
DOROTHY GERSHAN										Month 4 Day 23 Year 68										8:05 A.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
FEMALE			WHITE			APRIL 24, 1914			53 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
MASS.			U. S. A.						MONTGOMERY						Md.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
TAKOMA PARK			WASH. SAN. & HOSPITAL			SUPERVISOR			ADVERTISING																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																	
MD.			P. G. ✓			ADELPHI			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1823 KANAWHA STREET																	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																										
First Middle Last			First Middle Last																										
WOLFE			WASSERMAN			ETHEL			SCHWARTZ																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address																				
NO			021-05-8236			SIDNEY GERSHAN, Same as 13																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Hemorrhage</u>										2 days																			
431.9 DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
331X																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
			HOUR A.M. Month Day Year P.M. 19																										
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No.			City or Town			County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>4-21, 1968</u> , to <u>4-23, 1968</u> , that (I) (we) last saw the deceased alive on <u>4-22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED																				
<u>Isidore Shulman M.D.</u>									4-23-68																				
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
ISIDORE SHULMAN			915-19th St. N.W. Wash D.C.																										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)														
BURIAL			4-25-1968			NATIONAL MEMORIAL PARK			FALLS CHURCH						VA.														
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																				
GOLDBERG FUNERAL HOME			4217 9th St., N.W.			APR 25 1968			Charles Judge																				



02830

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

02830

DOROTHY GERSHAY

DATE: APRIL 24, 1944  
PLACE: MONTREAL  
U. S. A.

REASON: INVESTIGATION  
NATIONAL BUREAU OF INVESTIGATION  
1000 RAYMOND STREET  
WASHINGTON, D. C.

REPORTED BY: [Name]  
DATE: [Date]  
SUBJECT: [Subject]

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[Faint text block]

[Faint text block]

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[Faint text block]

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION  
DATE: [Date]  
SUBJECT: [Subject]



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Mary Virginia Glymph					ESTIMATED <input checked="" type="checkbox"/> 4 6 1968					8 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Female	W	July 16, 1937		30 YRS.	MONTHS DAYS		HOURS MIN.		Month Day Year	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
England		U.S.A				Montgomery Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		5300 Ventnor Rd.				Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5300 Ventnor Rd.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Charles				Edward Roach	Julia					Loughaton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Husband		ADDRESS		
No		Unknown		Benjamin Glymph		Same as Item 13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1746466/ Overdose of drug Dilantin</u> <u>9503</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>9718</u>										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		6 PM 4 6 1968		Took overdose of drugs - Dilantin						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		5300 Ventnor Rd. Bethesda. Montgomery Md						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		JOHN G. BALL				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		April 7, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Bethesda, Md.		
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/9/68		ft. lincoln cemetary		prince george co. md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
James Humphrey Funeral Home						DATE APR 11 1968		Charles Judge		
7557 Wisconsin Ave. Bethesda Md.										

10881

RECEIVED - DEPARTMENT OF AGRICULTURE

00887

RECEIVED

TO THE SECRETARY OF AGRICULTURE	
WASHINGTON, D. C.	
[Faint, illegible text in the main body of the form, possibly a letter or report.]	
[Faint, illegible text at the bottom of the form, possibly a signature or date.]	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05828									
05832									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ABRAHAM			ALBERT Goldstein			Month Day Year 4 14 68			11:22 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
male		white		3/7/00			68 YRS.		MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		United States				Montgomery County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross Hospital			SALES MANAGER			FIRE COVERIES
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Montgomery			Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
JACOB			GONDSTEIN			DORA EPERSTEIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
NO			21510-3555			ETHEL GONDSTEIN SAME AS 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Arteriosclerosis &amp; Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4201</u> (b) (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
<u>Arterioneurophrosclerosis; Cirrhosis of liver</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>4/14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert Kramer</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/14/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>				22e. ADDRESS <u>8484 16th St. SS. Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>BURIAL</u>		<u>4-16-68</u>		<u>NATL. MEM. PARK</u>		<u>FALLS CHURCH, VA.</u>			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
<u>Goldberg Funeral Home - 4217-9th St. NW DC</u>				<u>APR 16 1968</u>		<u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Filed by Medical Examiner 1500

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05829

05833

1. DECEASED-NAME (Type or print) <b>RICHARD</b>			First	Middle	Last	2a. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>9:15</b> M		
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>11/1/58</b>			6. AGE (In years last birthday) <b>9 1/2</b> YRS.		IF UNDER 1 YEAR MONTHS <b>9</b> DAYS <b>12</b>		IF UNDER 24 HRS. HOURS <b>9</b> MIN. <b>15</b>
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY County</b> Md.				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>2209 COLLEIDGE DR</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>STUDENT</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>2209 COLLEIDGE DR</b>	
14. FATHER'S NAME First <b>GERALD</b> Middle <b>—</b> Last <b>GOLIN</b>			15. MOTHER'S MAIDEN NAME First <b>CHARLOTTE</b> Middle <b>JOAN</b> Last <b>LEVY</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service) <b>—</b>			16b. SOCIAL SECURITY NO. <b>NONE</b>			17. INFORMANT <b>GERALD GOLIN</b>			Address <b>2209 COLLEIDGE DR</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY METASTASES</b> <b>1736</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RHABDOMYOSARCOMA OF BUTTOCK</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b> <b>1 1/2 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1971</b>											
19a. DATE OF OPERATION <b>9/66</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RHABDOMYOSARCOMA, BUTTOCK</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>8/10/68</b> , to <b>4/15, 1968</b> , that (I) (we) last saw the deceased alive on <b>4/13</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>George J. Cohen</b> MD DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>4/15/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>GEORGE J COHEN</b>						22e. ADDRESS <b>9919 GEORGIA AVE, SILVER SPRING MD</b>					
23a. BURIAL, CREMATION, ETC. (Specify)		23b. DATE <b>4-16-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATL. MEM. PARK</b>				23d. LOCATION (City or Town) (County) (State) <b>FALLS CHURCH VA</b>			
24. FUNERAL DIRECTOR <b>Charles J. Jones</b>						25a. REC'D BY REGISTRAR <b>Charles J. Jones</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			
DATE <b>APR 16 1968</b>											



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STATE OF TEXAS

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05830

## CERTIFICATE OF DEATH

05834

1. DECEASED-NAME (Type or print) <b>ELLEN E. GOTTSCHALK</b>			2a. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>68</u>			2b. HOUR <u>6<sup>00</sup></u> A M						
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>3/31/86</u>		6. AGE (In years last birthday) <u>82</u> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		
7a. BIRTHPLACE (State or foreign country) <u>New York</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.						
1d. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>4404 Colfax St.</u>			
14. FATHER'S NAME First Middle Last <u>JAMES</u> <u>Sweeney</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Elizabeth H</u> <u>Hawes</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>			16b. SOCIAL SECURITY NO. <u>057-168244</u>		17. INFORMANT Address <u>ARTHUR M. GOTTSCHALK</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA, RIGHT LUNG, MASSIVE</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1621</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work _____ at work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 8</u> , 19 <u>68</u> , to <u>Apr 18</u> , 19 <u>68</u> , that (I) <del>(we)</del> lost the deceased alive on <u>April 17</u> , 19 <u>68</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <u>(did not)</u> view the body after death.												
22b. SIGNATURE <u>Michel M. Healy MD</u>		22d. PHYSICIAN'S NAME (Type) <u>MICHEL M. HEALY</u>			22e. ADDRESS <u>5411 W Cedar La 205A Bethesda Md</u>		22c. DATE SIGNED <u>4/18/68</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-22-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>					
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>					25a. REC'D BY REGISTRAR DATE <u>APR 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

05831

05835

1. DECEASED-NAME (Type or print) <b>Leon William Graham Sr.</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>6:40 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White - Caucasian</b>		5. DATE OF BIRTH <b>3-3-1893</b>		6. AGE (In years lost birthday) <b>74</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Suburban Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>2107 Amherst Road.</b>		14. FATHER'S NAME First <b>William</b> Middle <b>Graham</b> Last <b>Graham</b>		15. MOTHER'S MAIDEN NAME First <b>Maida</b> Middle <b>Bowen</b> Last <b>Bowen</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b> (If yes give war or dates of service) <b>W.W.I</b>		16b. SOCIAL SECURITY NO. <b>196-10-2312</b>		17. INFORMANT Address <b>Mr. Leon G. Graham 2107 Amherst Rd. Hyattsville</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Staph. local</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pronchogenic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1621</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1621</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-2-68</b> , 19 <b>68</b> , to <b>4-10-68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-10-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John L. Ford</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>4-10-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN L. FORD MD</b>				22e. ADDRESS <b>831 UNIVERSITY BLVD E SILVER SPRING, MD 20901</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lancaster Penns.</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b> <b>Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <i>Eugene Gregory</i>		2a. DATE KNOWN OF DEATH MATED <i>April 3</i> 19 <i>68</i> <i>5:37</i> P. M.	
3. SEX <i>m</i>	4. RACE <i>w</i>	5. DATE OF BIRTH <i>May 24-1926</i>	6. AGE (In years last birthday) <i>42</i> YRS. MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN.
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.
10. CITY OR TOWN OF DEATH <i>Beltsville</i>	11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <i>Beltsville</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Excavator Heavy Equipment</i>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET AND NUMBER <i>Black Lock Road</i>
14. FATHER'S NAME First <i>Harley</i> Middle <i>Gregory</i> Last <i>Gregory</i>	15. MOTHER'S MAIDEN NAME First <i>Artie</i> Middle <i>Cooper</i> Last <i>Cooper</i>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>237-34-5587</i>		17. INFORMANT <i>Eugene Gregory</i> ADDRESS <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Bell</i> M.D.		22b. DATE SIGNED <i>April 3, 1968</i>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4-6-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Beltsville Church</i>	23d. LOCATION (City or Town) (County) (State) <i>Beltsville Montgomery Md</i>
24. FUNERAL DIRECTOR <i>Ernest C. Gartner,</i> <i>Ernest C. Gartner</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i> DATE <i>APR 8 - 1968</i>	

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OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D.C. 20315

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TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]

[Illegible text block containing multiple lines of faint, mirrored text, likely bleed-through from the reverse side of the page.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05832										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05837																																																																					
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR																																																																					
Maude										April 10 1968										12:18 PM																																																																					
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																																							
Female										White										12-21-90										77 YRS.										MONTHS										DAYS										HOURS										MIN.																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																																	
Maryland										USA																				Montgomery																																																											
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																											
Bethesda										Suburban																																																																															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																																																	
Md										Mont										Rockville										YES										243 E Montgomery Ave																																																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																							
Rasmus										West										Elizabeth										Fields																																																											
No										212-165-094A										Son - Lewis Grimes										Same as above																																																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																															
PART I. DEATH WAS CAUSED BY:																																																																																									
IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF																																																																															
4129										Cardiac Arrest																				30 min																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Intermittent Heart Disease with																				5 years																																																											
										DUE TO, OR AS A CONSEQUENCE OF										actual fibrillation + Cong Heart Failure																																																																					
										(c)																																																																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																																									
4200																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																																					
										HOUR A.M. Month Day Year P.M. 19																																																																															
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No.										City or Town										County										State																													
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																																																																																									
22a. I certify that (I) (this hospital) attended the deceased from										4/9/68										1968										to										4/10/68										1968										that (I) (we) last saw the deceased alive on										4/9/68										and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE										22c. DATE SIGNED																																																																															
Robert C. Macon										4/10/68																																																																															
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																															
Robert C. Macon										809 Viers Mill Rd, Rockville, Md																																																																															
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town)										(County)										(State)																																							
Burial										4/12/68										Forest Oak										Gaithersburg,										Md.																																																	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																																					
Tyson Wheeler										Rockville Pike																				Charles Judge																																																											
Rockville, Md.										DATE										APR 15 1968																																																																					

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "UNITED STATES" and "DEPARTMENT OF" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05834		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05838	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <b>Bertram</b>			First Middle Last <b>GROESBECK</b>		2a. DATE OF DEATH <b>April</b> Month <b>17</b> Day Year <b>68</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>June 18, 1894</b>		2b. HOUR <b>210A</b> M	
7a. BIRTHPLACE (State or foreign country) <b>Brooklyn N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		9. COUNTY OF DEATH <b>Montgomery</b> Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U. S. Navy</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Spain</b>		13b. COUNTY <b>Barcelona</b>		13c. CITY OR TOWN <b>Barcelona</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Bertram Groesbeck</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Elliott</b>		13e. STREET AND NUMBER <b>Villa Roel 204</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes 1917-53</b>		16b. SOCIAL SECURITY NO. <b>315-36-3290</b>		17. INFORMANT Address <b>Navy Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary carcinoma head of pancreas with lymph</b> <b>1570</b> DUE TO, OR AS A CONSEQUENCE OF <b>node metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>157x</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>April 12, 1968</b> , to <b>April 17, 1968</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>April 17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Herbert R. Brown, M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>April 18, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Herbert R. Brown, M. D.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-22-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>APR 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Stuart		A.		Haas	4		14	1968		M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		Month	Day	Year
M	White	12-24-52	15 YRS.			4		14	1968	11:30
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. COUNTY OF DEATH				
Jakoma Park	U. S. A.					Montgomery		Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring	Holy Cross Hospital	Student								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Md.	Montgomery	Silver Spring		11506 Uiers Mill Road						
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost			
Walter	A.		Haas	Lucile			Kimery			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	11506 Uiers Mill Road Silver Spring, Md.							
No	No	Walter A. Haas								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cardiorespiratory failure due to										
9502 DUE TO, OR AS A CONSEQUENCE OF										
(b) Overdose of Etrafon, self administered										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Depression										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH		630 P.M. 4-13 19 68		Deceased took overdose of etrafon						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		Silver Spring		Mntg		Md		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED		
Belden R. Reap								4/14/1968		
EXAMINER'S NAME (Type)		Belden R. Reap, M.D.		ADDRESS (Street, City, Town, or County)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
Burial		4/17/1968		Parklawn		Rockville, Montgomery, Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
C. G. Carter, 8434 Warner E. Pumphrey Inc. Silver Spring, Md.		DATE APR 18 1968		Charles Judge						

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PHYSICAL EXAMINATION REPORT

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED			2b. HOUR		
Lenore M. Hagen						April 25 1968			6:40 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Female	White	Dec 21/1912	55 YRS.			April 25 1968			4:10 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Wisconsin.		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			4400 East West Highway			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Md.			Montgomery			Bethesda			4400 East West Highway		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Leonard Hill			Margaret Ward								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			Unknown			Husband Fay W. Hagen			Same as Item 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arteriosclerosis with occlusion									Sudden		
410.9 DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease									years.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			JOHN G. BALL			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			4/26/68		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Cremation			4-26-68		Cedar Hill Crematory			Suitland, Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE APR 29 1968		Charles Judge			

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MEDICAL CERTIFICATION

05837		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05841	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last LULU W. HAINES			2a. DATE OF DEATH Month Day Year April 22, 1968			2b. HOUR 1:50 PM	
3. SEX Female		4. RACE Caus.		5. DATE OF BIRTH July 24, 1870		6. AGE (In years last birthday) 97 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley N. H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Lynwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER --		14. FATHER'S NAME First Middle Last James S. Windsor		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Rebecca Darby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Neice # 8 Thomas St. Mrs. R. Chinn Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4221</u> (b) <u>arteriosclerotic cardiovascular disease 5 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>fall, with non-displaced chip fracture of left hip 4/17/68.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
19a. DATE OF OPERATION <u>none</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 7 P.M. April 17 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>fall in hall.</u>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>running down</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Potomac Valley - Rockville Montgomery Co.</u>			
22a. I certify that (I) (this hospital) attended the deceased from <u>October, 1966</u> , to <u>April 22, 1968</u> that (I) (we) last saw the deceased alive on <u>April 21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>W. A. Linticum</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/22/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>W. A. Linticum, M.D.</u>		22e. ADDRESS <u>110 S. Washington St. Rockville</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-25-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Darnestown, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>APR 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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W. White M.D. covering for R. Benson M.D.  
cleared to sign below page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05833

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

05842

1. DECEASED-NAME (Type or print) First Middle Last <i>Claudia Joyce HALL</i>			2a. DATE OF DEATH Month Day Year <i>April 13 1968</i>			2b. HOUR MIN <i>6 42 P. M.</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1-16-09 1910</i>		6. AGE (In years last birthday) YRS. <i>58 10X</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Okla.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Wheaton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Handolph Hills Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>			13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>13408 Grenada Dr.</i>	
14. FATHER'S NAME First Middle Last <i>Moody Hines</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Dessie Knight</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT <i>Mrs. Marion Coleman Rockville, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>4120</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Brain Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive Cardiovascular Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 Days</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <i>443X</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>66</i> , to <i>13 April</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10 April</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Merton L. White M.D.</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>13 April 68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Merton L. White</i>					22e. ADDRESS <i>9911 Georgian Lane Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Incumburi Memo. Park</i>			23d. LOCATION (City or Town) (County) (State) <i>Incumburi, New Mexico</i>			
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc. Silver Spring, Md.</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
25c. ADDRESS <i>Warner E. Pumphrey, Inc. Silver Spring, Md.</i>					25d. DATE <i>APR 17 1968</i>					

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
TONI ERIKA HALL								MAY 4-23 1968		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
F	W	3-2-68		YRS. 15		MONTHS 5		DAYS 23		Month 4 Day 23 Year 68	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md.	
TENN.				WIDOWED		DIVORCED		MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
TAK. PARK.		WASH. SAN + HOSP.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND.		MONTGOMERY		TAK. PARK		YES <input type="checkbox"/> NO <input type="checkbox"/>		7709 CARROLL AVE.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
GEORGE A. HALL								LEODA MULLINS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
				NONE		GEORGE A. HALL		7709 CARROLL AVE TAKOMA PARK MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Sudden death in Infancy											
795X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
795X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
22b. DATE SIGNED											
4/23/1968											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER							
Belden R. Reap				M.D.							
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER							
BELOEN R. REAP M.D.				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATOR			
				April 25, 1968				Regersville			
24. FUNERAL DIRECTOR				25a. ADDRESS				25b. REGISTRAR'S SIGNATURE			
Arthur Walters				254 Carroll St. N.E.				Charles Judge			
				DATE				APR 25 1968			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
THOMAS JACKSON HARDING						Month 4 Day 24 Year 68		11:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		CAUCASIAN		9-25-1892		75 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING		BELMONT NURSING HOME			POLICE		MONT. CO.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND		MONTGOMERY		SILVER SPRING		NO <input type="checkbox"/>		15501 THOMPSON RD	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
JAMES HENRY HARDING			ADA MOORE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO					Address BELMONT NURSING HOME 18220 NEW HAMPSHIRE, SS MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u>								2-3 mths	
410.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis heart disease</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>bronchopneumonia</u>								10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Semility &amp; emaciation (Refused to eat)</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-25-65</u> , 19 <u>65</u> , to <u>4-24-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-18-68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		22c. DATE SIGNED	
<u>John R. Spencer MD</u>						<input checked="" type="checkbox"/>		4-24-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
JOHN R. SPENCER, MD				BURTONSVILLE, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>April 27, 1968</u>		<u>Union Cemetery</u>		<u>Burtonsville</u> (County) (State)		<u>Md.</u>	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>J. Arthur Walters</u>				<u>254 Center St NW Wash. D.C.</u>		DATE		<u>Charles Judge</u>	
						APR 25 1968			

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PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RMA. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18, 22a film 401 MARYLAND STATE DEPARTMENT OF HEALTH  
6-19-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05845

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH				<input type="checkbox"/> Month	Day	Year	2b. HOUR
Lulu Irene Hare						4 19 1968							9:30
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD				2d. HOUR	
female	White	11/25/79	88 YRS.					April 19 1968				9:30 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Iowa		U.S.A.				Montgomery Md.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Olney			Montgomery Gen. Hosp.			physician			medicine				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER			
Maryland			Montgomery			Silver Spring				3320 Chiswick Court			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
George Minor Waters						Mary Eckles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT							
no			579-52-6929			records ADDRESS Montgomery Gen. Hospital, Olney, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction with Occlusion</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <u>Arteriosclerotic Heart Disease</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			Belden R. Reap			M.D.			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			Belden R. Reap, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			4/20/1968				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)	
cremation			4/22/68		Cedar Hill Crematory			Suitland, Maryland					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Jos. Gawler's Sons, 5130 Wisc. Av. NW Wash. DC								DATE		APR 24 1968			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05842					05846				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
SUSIE M. HARGIS					Month Day Year APRIL 15 1968		8 59 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		JUNE 27 1875		92 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
TENNESSEE		U.S.A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		FAIRLAND NURSING HOME 2101 FAIRLAND RD.		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince Georges Co.		ADAPL		YES		3321 POWDER MILL RD.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First Middle Last Jacob Pesteefield		First Middle Last Sarah Jane Mason		NO		411-12-8787		Charles W. King	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 1-2 days 485X DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure 2 wks (b) DUE TO, OR AS A CONSEQUENCE OF Bronchopneumonia 19 days (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 491X Crystals - deaf & blind - moribund									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 7-15, 1965 to 4-15, 1968, that (I) (we) last saw the deceased alive on 4-12-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John R. Spencer				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-15-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS BURTONSVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)			
Burial		4/19/1968		West Hill Cemetery		Chattanooga		TENNESSEE	
24. FUNERAL DIRECTOR J. Arthur Walters				24a. ADDRESS 411 W. Wash. 12, D.C.		25a. REC'D BY REGISTRAR APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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RECEIVED IN DEAN

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "received" and "in" are faintly visible.]*

Page 11 000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
30M REV. 1/68

05842		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05847											
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH			2b. HOUR							
Connie				Ann		Harmon	April	Month	20	Day	68	Year	5	PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.						
Female		Caucasian		8-8-15			53 YRS.		MONTHS		OAYS		HOURS	MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										
Wash. D.C.		U.S.					Montgomery Md.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring		Holy Cross Hospital Acct. Tech						U.S. Tariff Comm.									
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
Maryland		Montgomery		Silver Spring				1001 Spring St.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Paul				Ricucci				Eugenia									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. NEOMANT		James R. Harmon, Jr. 4032 7th St., N.E. Washington, D.C.									
No				266-34-4306													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 1992																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
						3/6/68 4/20/68											
22a. I certify that (I) (this hospital) attended the deceased from 3/6/68, 19, to 4/20/68, 19, that (I) (we) last saw the deceased alive on 4/20/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE				ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED							
HENRY C. SERUGES										4/20/68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS															
HENRY C. SERUGES MD		5413 Cedar Lane Bethesda Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
Burial		Apr. 24, 1968		Gate of Heaven Cemetery				Silver Spring, Maryland									
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR														25b. REGISTRAR'S SIGNATURE	
Warner C. Pumphrey, Inc.		443 Georgia Ave. Silver Spring, Md.														APR 23 1968 Charles Judge	

22330

1942

OFFICE OF THE SECRETARY OF THE ARMY

MEMORANDUM FOR THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05844		05848	
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>11716 Knottree Road</u>	
3. NAME OF DECEASED (Type or print) <u>ESTELLA B</u> First Middle Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>22</u> Year <u>1968</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 5, 1898</u> 9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Sterling Price Buttry</u>		14. MOTHER'S MAIDEN NAME <u>Ella Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-30-3136</u>	
17. INFORMANT <u>Daughter</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE DUODENUM</u> DUE TO (b) <u>METASTASIS</u> DUE TO (c) <u>ADENOCARCINOMA RT. LUNG</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>19</u> p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>SEPT. 1, 1932</u> to <u>4/22, 1968</u> that (I) <del>(we)</del> last saw the deceased alive on <u>4/22, 1968</u> , and that death occurred at <u>7:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Bradley D Hodgkins</u>		22b. DATE SIGNED <u>April 22, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>BRADLEY D. HODGKINS M. D.</u>		22d. ADDRESS <u>4413 Bradley Lane, Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-26-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park, Falls Church, Va.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 29 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>

MEDICAL CERTIFICATION





02844

DEPARTMENT OF DEATH

02844

Name		Last		First		Middle	
Date of Birth		Month		Day		Year	
Sex		Male		Female			
Race		White		Black		Other	
Religion		Catholic		Protestant		Other	
Marital Status		Single		Married		Widowed	
Occupation		Student		Worker		Other	
Address		Street		City		State	
County		Fulton		City		State	
Date of Death		Month		Day		Year	
Cause of Death		Natural		Accident		Suicide	
Place of Death		Home		Hospital		Other	
Signature		Name		Title		Date	



05845

## CERTIFICATE OF DEATH

05849

1. DECEASED-NAME (Type or print) <i>Ethel M. Harris</i>			2a. DATE OF DEATH Month <i>APRIL</i> Day <i>6</i> Year <i>1968</i>			2b. HOUR <i>3:50</i> PM	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>August 17, 1900</i>		6. AGE (In years last birthday) <i>67</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Not known</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Damascus</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>26420-Ridge Road</i>		14. FATHER'S NAME First <i>Marion</i> Middle <i>Marlowe</i> Last <i>Marlowe</i>		15. MOTHER'S MAIDEN NAME First <i>Virginia</i> Middle <i>Ann</i> Last <i>Jarbo</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>570-22-4209</i>		17. INFORMANT <i>William S. Harris, Jr., Damascus, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Bronchopneumonia</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchiogenic Carcinoma LLL lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>about 6 mos?</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1621</i>							
19a. DATE OF OPERATION <i>3/22/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca left lung</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/18</i> , 19 <i>68</i> , to <i>4/6</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/5</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Marvin L. Kolkin M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/6/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Marvin L. Kolkin, M.D.</i>				22e. ADDRESS <i>1015 Spring St., Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 8, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		23d. LOCATION (City or Town) (County) (State) <i>Frederick, Md.</i>	
24. FUNERAL DIRECTOR <i>Olin L. Molesworth, Damascus, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 9 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15820

UNITED STATES OF AMERICA

15820

IN SENATE  
January 15, 1914  
REPORT  
OF THE  
COMMISSIONER OF THE  
GENERAL LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
JANUARY 14, 1914

AND  
OF THE  
COMMISSIONER OF THE  
GENERAL LAND OFFICE  
IN RESPONSE TO A  
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VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Henry matthew Hartman					2a. DATE OF DEATH Month Day Year 4-5-68			2b. HOUR 9:30 A M	
3. SEX male		4. RACE white		5. DATE OF BIRTH 3-17-02		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Arts & Crafts		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4710 Cherokee	
14. FATHER'S NAME First Middle Last Edward Hartman			15. MOTHER'S MAIDEN NAME First Middle Last Florence m. Paul						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 26-05-1620		17. INFORMANT Ann Hartman				Address 4607 Cherokee ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - cardiac failure. 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - massive coronary infarction. DUE TO, OR AS A CONSEQUENCE OF (c) - coronary heart disease. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 NO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-2-1968, to 4-5-1968, that (I) (we) last saw the deceased alive on 4-5-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Veronica Troost				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-5-68	
22d. PHYSICIAN'S NAME (Type) VERONIKA TROOST.				22e. ADDRESS 10236 N. H. Ave, Seenspring Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/8/68		23c. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Combruse Inc. 1328 Sulphur Sp. Rd.				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

7328

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05647

05851

FOR STATE  
HEALTH DEPT

1. DECEASED-NAME (Type or Print) <u>Frank Joseph Hoske</u>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>April</u> Day <u>13</u> Year <u>1968</u>			2b. HOUR <u>3:35</u> P.M.		
3. SEX <u>M</u>	4. RACE <u>W.</u>	5. DATE OF BIRTH <u>April 1917</u>	6. AGE (In years last birthday) <u>51</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <u>April</u> Day <u>13</u> Year <u>1968</u>		
7a. BIRTHPLACE (State or foreign country) <u>D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.		
10. CITY OR TOWN OF DEATH <u>Bethesda</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Congressional Clerk</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. CITY OR TOWN <u>Montgomery</u>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>5815 Ridgeway Ave</u>
14. FATHER'S NAME First <u>Frank Joseph</u> Middle <u>Hoske</u> Last <u>Sr.</u>			15. MOTHER'S MAIDEN NAME First <u>O'Hill</u> Middle <u>Marie</u> Last <u>Vink</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>None</u>			16b. SOCIAL SECURITY NO. <u>577097299</u>			17. INFORMANT <u>Timothy Hoske</u> ADDRESS <u>Same as above</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>411.9 Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____		City or Town _____	County _____ State _____
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>John G. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>April 13, 1968</u>		
EXAMINER'S NAME (Type) <u>John G. Ball</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) _____								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>4/15/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) _____ (County) <u>Prince George Co., Maryland</u> (State) _____		
24. FUNERAL DIRECTOR <u>Lyson Wheeler Funeral Home</u> ADDRESS <u>Rockville, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



13887

UNITED STATES DEPARTMENT OF AGRICULTURE

13887

UNITED STATES DEPARTMENT OF AGRICULTURE



Handwritten notes or signatures in the left margin.

Vertical text or list of items in the left margin.



APR 11 1928



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Robert Bruce Hatt						Month Day Year		1968 9 12		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Male	White	7-8-84	83 YRS	MONTHS DAYS		HOURS MIN.		Month Day Year		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.		U. S. A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington San. & Hosp.			Machinist		Westinghouse		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Jacob Hatt			Dorothy Grove							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
No			169-095411			Washington San Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Generalized Carcinomatosis										
DUE TO, OR AS A CONSEQUENCE OF										
(b) due to Cancer of Lung										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
163X										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH			HOUR A.M. P.M.							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22b. DATE SIGNED										
4/12/1968										
22c. CHIEF MEDICAL EXAMINER			22d. DEPUTY MEDICAL EXAMINER							
Belden R. Reap M.D.			Charles Judge							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			April 15, 1968		St. Lucian		Hagerstown Md			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Arthur Walters			254 Carroll St		Charles Judge					
			DATE		APR 15 1968					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, antemovial, and in any event, within 72 hours after death.

3- Cleared with Medical Examiner - 4/5/68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR						
Creighton Ainly Haughn						APRIL 4 1968		10:57 PM						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS						
Male		White		November 12, 1894		73 YRS.		IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Canada		America				Montgomery Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
Takoma Park			Washington Sanitarium			Sea Captain								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland			Montgomery		Takoma Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7327 Carroll Avenue					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
John			A		Haughn	Leticha Parsons					Shackle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
yes			Canadian Navy			023-18-4878			Patient's chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <i>Circ. Myocardial infarction.</i>										1 day				
410.9 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thromb. A coronary artery</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Failure, acute</i>										Days				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
420.1 <i>Interoschism, coronary - old infarction 3 yrs ago</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		HOUR A.M. Month Day Year P.M. 19												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4/4/1968 to 4/4/1968, that (I) (we) last saw the deceased alive on 4/4/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
Chas H Volokton, MD									April 5, 1968					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS									
Chas H Volokton, MD					831 Univ. Blvd. E Silver Spring									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)			
Burial		4/8/68		Parklawn Cemetery			Rockville		Montgomery		Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
C. Glen Carter					Warner E. Pumphrey Inc. 8434 Georgia Ave. SS		APR 11 1968							

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APR 11 1964

4/11/64

10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05850		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05854		
DECEASED NAME (Type or print) <u>MORRIS</u> First Middle Last				2a. DATE OF DEATH Month Day Year <u>April 12 1968</u>		2b. HOUR <u>P. 6:00 PM</u>
3. SEX <u>Male</u>	4. RACE <u>Cauc.</u>	5. DATE OF BIRTH <u>5-2-1900</u>		6. AGE (In years last birthday) <u>67</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md.
10. CITY OR TOWN OF DEATH <u>CHEVY CHASE</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>BETHESDA SILVER SPRING</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>WASH. STATE MILITARY</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>LIQUOR</u>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>SILVER SPRING</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER <u>1900 LYTONSVILLE RD.</u>		14. FATHER'S NAME First Middle Last <u>Yelenda</u> <u>HECKMAN</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>PATIENT'S CHART</u>		Address
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>-</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>578-01-7326</u>		17. INFORMANT <u>PATIENT'S CHART</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>170X</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>67</u> , to <u>April 12</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>April 12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) (did not) view the body after death.						
22b. SIGNATURE <u>BLAINE H. HEIG, M.D.</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>April 12, 1968</u>
22d. PHYSICIAN'S NAME (Type) <u>BLAINE H. HEIG, M.D.</u>				22e. ADDRESS <u>9801 Bay View Road</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>April 15, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Fall Church Va</u>
24. FUNERAL DIRECTOR <u>BERNARD DARRANSKY &amp; SONS</u> <u>3501-14th STREET, N.W. - WASH. D.C. 20010</u>				25a. REC'D BY REGISTRAR DATE <u>APR 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



03334

RECEIVED OF BAY

07330



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

APR 1 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>WEEKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MANOLPH HILLS NURSING HOME</u>		d. STREET ADDRESS <u>923 LEWIS AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>R.</u> Last <u>HENLEY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>6</u> Year <u>1968</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1886</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCIENTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAVE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT C. HENLEY</u>		14. MOTHER'S MAIDEN NAME <u>LAURA KUNKEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>519-58-5936</u>	
17. INFORMANT <u>MRS. MAIDEN HENLEY</u>		Address <u>923 LEWIS AVE. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1890 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertrophoma, rt. Kidney</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>180x Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>9 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>April 5</u> , 19 <u>68</u> , that (2) (we) last saw the deceased alive on <u>April 4</u> , 19 <u>68</u> , and that death occurred at <u>3:15</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>James R. Coleman MD.</u>		22b. DATE SIGNED <u>April 6, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING, MARYLAND.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>APRIL 9, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Colmar Manor MD.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>254 Carroll St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>APR 9</u>		19 <u>68</u>	

25821



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05852

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05856

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR		
Lida		A		Hicks				4		6	1968	7			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
Fe.	W.	Nov. 28 1870		97 YRS						April		6	1968	7	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH									
New Jersey		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY									
Kensington		Carroll Hall Nursing Home		RETIRED U.S. Post Office		U.S. Gov't.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Va.		Arlington		Arlington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4411 N. Henderson Rd.							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Daniel		Hicks		Mary		Carlyle									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				229-60-4678		Mrs. Robert C. Huston		ARLINGTON VIRGINIA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> years															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>John G. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>April 6, 1968</u>							
EXAMINER'S NAME (Type) JOHN G. BALL				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ADDRESS (Street, city, town, or county)															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE April 9, 1968				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery							
23d. LOCATION (City or Town) (County) (State) Suitland, Maryland				24. FUNERAL DIRECTOR Arlington Funeral Home 3901 N. Fairfax Drive by: Ben E. Rogers, Jr. Arlington, Va. 22203				25a. REC'D BY REGISTRAR DATE APR 9 - 1968							
25b. REGISTRAR'S SIGNATURE Richard Jones															

52320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05853		05857									
1. DECEASED-NAME (Type or print)		First Middle Lost		2a. DATE OF DEATH		2b. HOUR A					
Tommy		Lee		Hicks		Month Day Year April 6 1968 7:18 M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		15 November 1933		34 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Tennessee		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		The Clinical Center, NIH		Barber							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Tennessee				Athens				Route #4			
14. FATHER'S NAME		First Middle Lost		15. MOTHER'S MAIDEN NAME		First Middle Lost					
Newton		Hicks		Minnie		Watts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		The Medical Record Address					
No		413-52-5252		The Clinical Center, NIH, Bethesda, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
7469				Heart Failure				2 1/2			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Congenital Heart Disease				34 years			
7542		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Pneumonia, Renal Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
3/19/68		Ventricular Septal Defect		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (A) (this hospital) attended the deceased from 12 March, 1968, to 6 April, 1968, that (A) (we) last saw the deceased alive on 6 April 1968, and that in (XXX) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
		Don E. Detmer, M.D.						6 April 1968			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Don E. Detmer, M.D.		The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		4/10/1968				ATHENS TENN.					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
W. W. CHAMBERS, CO. ADDRESS		APR 11 1968		J. Charles Judge							
5801 CLEVELAND AVE. RIVERDALE, MD.											

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1. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

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1. The first group of people who are not in the labor force are those who are not in the labor force because they are not in the labor force.

1. *Chlorophyll a* (Chl *a*)

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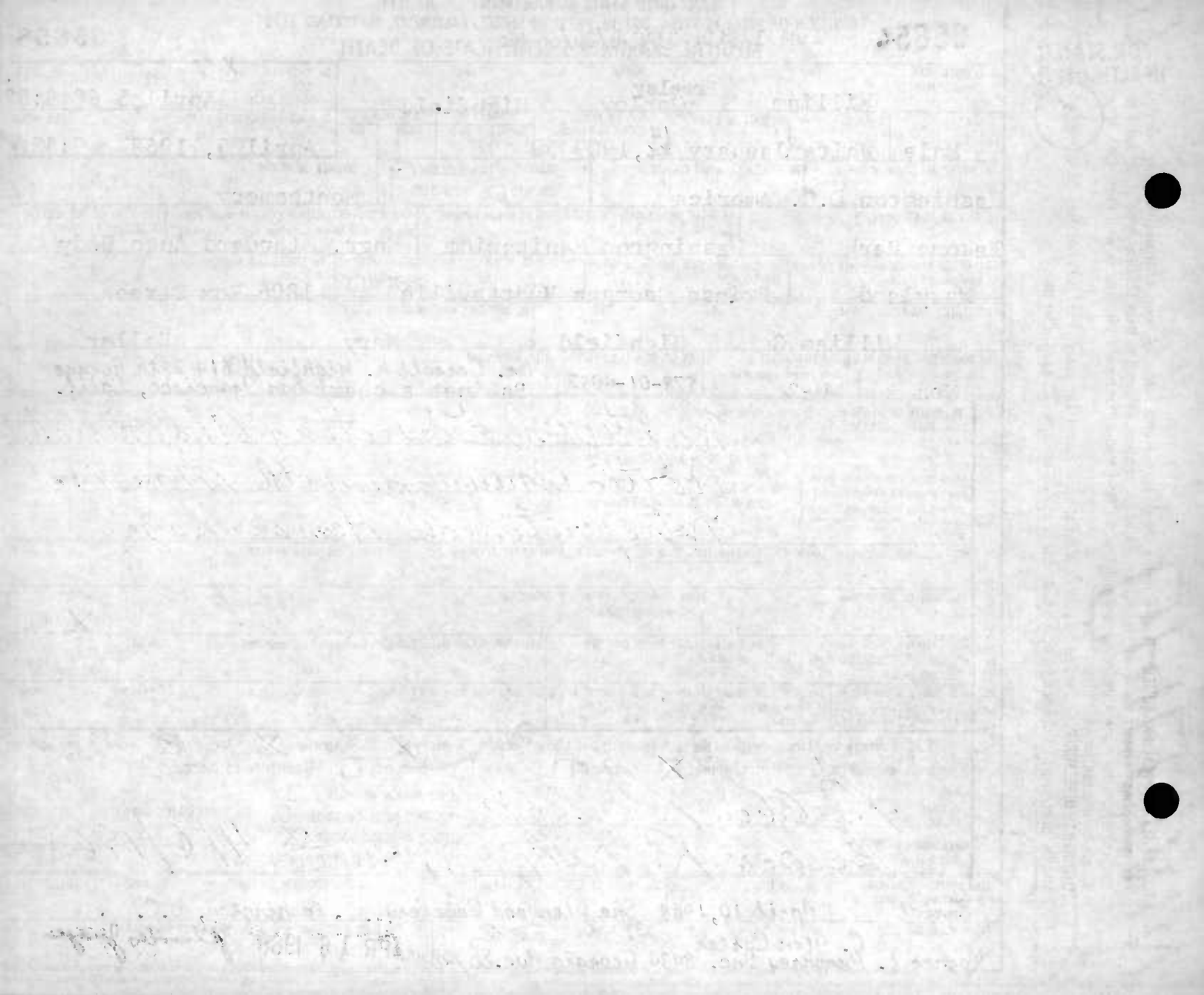


# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR		
William Greeley Highfield			William	Greeley	Highfield	April 5 1968		April	5	1968	9:52 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS. DAYS	9. UNDER 24 HRS. HOURS	10. UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
Male	White	January 12, 1909	59					April 5, 1968		19	9:52 PM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		9. COUNTY OF DEATH					
Washington D.C. America						NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery				Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park			Washington Sanitarium			Mngr. Standard Auto Body							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Prince Georges Hyattsville									1806 Fox Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
William G Highfield			William G	Highfield		Mary Keller			Mary	Keller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes			WW-2			Mr. Carroll R. Highfield			619 28th Avenue				
			578-01-4052			Pafinet's chart			San Francisco, Calif.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Ruptured Dissecting Abdominal													
DUE TO, OR AS A CONSEQUENCE OF													
441.0													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) Aortic Aneurysm with Massive													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Retroperitoneal Hemorrhage													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
451X													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A.M. P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED							
EXAMINER'S NAME (Type)			M.D.			ASSISTANT MEDICAL EXAMINER							
Belden R. Reap						DEPUTY MEDICAL EXAMINER							
			ADDRESS (Street, City, County, State)										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			April 10, 1968			The Glenwood Cemetery			Washington, D.C.				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
C. Glen Carter			DATE			APR 16 1968			Charles Judge				
Warner E. Pumphrey Inc. 8434 Georgia Ave. S.S. MD													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

05855		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05859					
1. DECEASED-NAME (Type or print) <i>Marcielle Helserath</i>						2a. DATE OF DEATH Month <i>April</i> Day <i>19</i> Year <i>1968</i>		2b. HOUR <i>5:19</i> M			
3. SEX <i>F</i>		4. RACE <i>W.</i>		5. DATE OF BIRTH <i>2-17-17</i>		6. AGE (In years lost birthday) <i>51</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Therapist</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>9216 Parkside Rev.</i>			
14. FATHER'S NAME First <i>William</i> Middle <i>Paul</i> Last <i>Paul</i>		15. MOTHER'S MAIDEN NAME First <i>Hazel</i> Middle <i>Lidell</i> Last <i>Lidell</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <i>No.</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>140-039476</i>		17. INFORMANT <i>Charles Helserath</i>		Address <i>same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage, massive, spontaneous</i> <i>4309</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ruptured berry aneurysm, left middle cerebral artery.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>330X</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>4/16</i> , 19 <i>68</i> , to <i>4/19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard H. Pollen MD</i>		22c. DATE SIGNED <i>4/20/68</i>		22d. PHYSICIAN'S NAME (Type) <i>RICHARD H. POLLEN MD</i>							
22e. ADDRESS <i>10400 CONNECTICUT AVE, KENSINGTON MD.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-21-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Garden</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Va.</i>					
24. FUNERAL DIRECTOR <i>Donald M. Stein</i>		ADDRESS <i>232 Carroll</i>		25a. REC'D BY REGISTRAR <i>Hebrew Memorial Funeral Home</i>		25b. REGISTRAR'S SIGNATURE <i>St. NW, Wash. D.C.</i>		DATE <i>APR 22 1968</i>			

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## CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>TORKEL</b>			First Middle Last			2a. DATE OF DEATH Month <b>1</b> Day <b>1968</b> Year			2b. HOUR <b>210P M</b>		
3. SEX <b>MALE</b>			4. RACE <b>CAUC</b>			5. DATE OF BIRTH <b>9 APRIL, 1906</b>			6. AGE (In years last birthday) <b>61</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>DENMARK</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NAVAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>STATE DEPARTMENT</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. VIRGINIA</b>			13b. COUNTY <b>MORGANTOWN</b>			13c. CITY OR TOWN <b>MORGANTOWN</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>---</b>			14. FATHER'S NAME First <b>POUL</b> Middle <b>HOLSOE</b> Last <b>MARGRETE HELSTED</b>			15. MOTHER'S MAIDEN NAME First <b>MARGRETE</b> Middle <b>HELSTED</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WWII</b>			16b. SOCIAL SECURITY NO. <b>280 01 1064</b>			17. INFORMANT <b>De PAUW UNIVERSITY GREENCASTLE, IND.</b> <b>SVEND E. HOLSOE, AFRICAN STUDIES SECTION</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GRAM NEG. SEPTICEMIA</b> <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHIAL PNEUMONIA WITH ABSCESS FORMATION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>491X</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>FEB. 22</b> , 19 <b>68</b> , to <b>APR. 1</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 1</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (view) view the body after death.											
22b. SIGNATURE <b>R. W. VIRGILLIO, M.D.</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>APRIL 2, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>R. W. VIRGILLIO, M.D.</b>						22e. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>			23b. DATE <b>4/3/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CREMATORY</b>			23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG, MD.</b>		
24. FUNERAL DIRECTOR <b>S. H. HINES CO.</b>						25a. REC'D BY REGISTRAR DATE <b>APR 5 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		
2901-07 14th STREET, N.W. WASHINGTON, D.C.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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Coroner notified & approved. R.B.A.

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MEDICAL CERTIFICATION

05857				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05861			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR			
James Allen Hoffman				April 13 1968				7:00 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		11-17-84		83 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Penn		U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park, Md.		Washington Smitar		Retired		Lawyer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
D.C.				Washington				1131 Fern St. N.W.			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
James Lincoln Hoffman				Ellen Peters							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				579-60-3323		Mrs. Joseph Strizak		7004 Poplar Avenue Takoma Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral Thrombosis										2 mos.	
433.9 DUE TO, OR AS A CONSEQUENCE OF											
(b) Severe Generalized Arteriosclerosis										10 yrs.	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Severe Anemia, Intertrochanteric Fracture of Right Hip, Parkinson's Disease, Pyelonephritis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
9/20/67		Pinning of Right Hip		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		5:00 P.M. Sept. 19 1967		Patient fell in his room & broke his right hip.							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	
		Colonial Villa Nursing Home		12325 New Hampshire Ave.				Silver Spring, Md.		Montgomery	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1958, to 13 April, 1968, that (I) (we) last saw the deceased alive on 13 April 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Russell B. Arnold M.D.										4/13/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
Russell B. Arnold M.D.				1106 Spring Street Silver Spring, Md. 20910							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		April 16, 1968		Cedar Hill Cemetery		Suitland, Maryland					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.				8434 Georgia Ave. Silver Spring, Md.		DATE APR 18 1968		John J. Judge			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR			
Charles Henry Homer, SR.						Month Day Year			Hour			
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
M.			W.		Sept. 7, 1906		61 YRS.		MONTHS DAYS HOURS MIN		Month Day Year	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH			
Wash. D.C.			U.S.A.			NEVER MARRIED			Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Suburban			New Printing Office						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Maryland			Montgomery			Bethesda			YES NO			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			
Oscar			Emma			Navy			213-42-8385			
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
James B. Homer			Home			PART 1. DEATH WAS CAUSED BY:			Sudden.			
						IMMEDIATE CAUSE (a)			Coronary Insufficiency Acute			
						DUE TO, OR AS A CONSEQUENCE OF			4109			
						(b)			Cardio Vascular Disease			
						DUE TO, OR AS A CONSEQUENCE OF			Years			
						(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
4201												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES NO				
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				P.M. 19								
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State				
WHILE AT WORK NOT WHILE AT WORK												
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner												
22b. DATE SIGNED				22c. REGISTRAR'S SIGNATURE								
4/29/68				John G. Ball								
22d. REGISTRAR'S SIGNATURE				22e. REGISTRAR'S SIGNATURE								
Charles Judge												
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				
Burial				5-2-68				Rock Creek Cemetery				
23d. LOCATION (City or Town) (County) (State)				23e. REC'D BY REGISTRAR				23f. REGISTRAR'S SIGNATURE				
Washington, D. C.				DATE				MAY 2 1968				
24. FUNERAL DIRECTOR				ADDRESS				25a. REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY, Bethesda, Maryland								Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Bernadette C. Hopkins			2a. DATE OF DEATH April 22 1968		2b. HOUR 4:15 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH 10/23/91		6. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Fed. Gov't - Retired	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1810 August Dr.	
14. FATHER'S NAME First Middle Last John I Hopkins	15. MOTHER'S MAIDEN NAME First Middle Last Mary Holden				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT Nosep Reed Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445.0 gangrene both legs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) phlebotrombosis DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 1 MONTH 5 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4501 acidosis, azotemia diabetes mellitus					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/20, 1968, to 4/22, 1968, that (I) (we) last saw the deceased alive on 4/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Henry W. Stout MD	22c. DATE SIGNED 4/22/68	22d. PHYSICIAN'S NAME (Type) HENRY W. STOUT			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4-25-1968	23c. NAME OF CEMETERY OR CREMATORY Redden Hill	23d. LOCATION (City or Town) (County) (State) Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR MATTHEW L. HOPKINS	25a. REC'D BY REGISTRAR APR 24 1968		25b. REGISTRAR'S SIGNATURE James Judge		



STATE OF NEW YORK

200000





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05864

1. DECEASED-NAME (Type or print) First Middle Last <b>CLEADA BROMLEY HORN</b>			2a. DATE OF DEATH Month Day Year <b>April 11, 1968</b>		2b. HOUR <b>9:41</b> M
3. SEX <b>Female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>Nov. 25, 1897</b>		6. AGE (In years last birthday) <b>70</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5015 Battery Lane</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Pharmist</b>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5015 Battery Lane</b>			
14. FATHER'S NAME First Middle Last <b>William R. Bromley</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Julie Etta Johnson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-03-2027</b>		17. INFORMANT Husband <b>James P. Horn</b>	
				Address <b>Same as Item 13.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> <b>4/29</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4200</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5 Sept, 1965</b> , to <b>11 April, 1968</b> , that (I) (we) last saw the deceased alive on <b>10 April, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>SEERE S. DAVEN</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12 April 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>SEERE S. DAVEN</b>		22e. ADDRESS <b>4977 Battery Lane Bethesda Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-15-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>					
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 17 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

03330

RECEIVED

03330



03330

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05861		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05865	
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		
First Middle Last <i>Amelia Magaien Horner</i>					Month Day Year <i>April 6 1968</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>12/17-91</i>		6. AGE (In years last birthday) <i>76</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i> Md.	
10. CITY OR TOWN OF DEATH <i>Takeima Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium &amp; Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>PRINCE GEORGE'S</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13e. STREET AND NUMBER <i>10808 Bermdale Drive</i>	
14. FATHER'S NAME First Middle Last <i>Charles B. Kremer</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Ellen - Shoemaker</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>			
16b. SOCIAL SECURITY NO. <i>577-05-3847D</i>		17. INFORMANT Address <i>Washington Sanitarium &amp; Hosp. Takeima Park Md 20012</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4500</i> (b) <i>INanition, generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Age</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Terminal</i> <i>6 mos</i> <i>76 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hodgkins disease of Liver, &amp; Surgery on colon</i>							
19a. DATE OF OPERATION <i>March 4 '68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Sigmoid Polyp &amp; Liver Node</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 10, 1968</i> , to <i>April 6, 1968</i> , that (I) (we) last saw the deceased alive on <i>April 5, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W.W. Eastman</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>April 6, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>W.W. EASTMAN</i>				22e. ADDRESS <i>831 University Blvd E, Silver Spring Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4/9/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>BLADENSBURG, MD.</i>	
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SONS</i>				ADDRESS <i>5130 WIS. AVE. N.W. WASHINGTON, D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 10 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

100200

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY AND NAVAL STORES

100200

TO THE DIRECTOR OF THE BUREAU OF THE ARMY AND NAVAL STORES  
 FROM THE DIRECTOR OF THE BUREAU OF THE ARMY AND NAVAL STORES  
 SUBJECT: [Illegible]  
 [The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing various items and their status.]

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY AND NAVAL STORES  
 FROM THE DIRECTOR OF THE BUREAU OF THE ARMY AND NAVAL STORES  
 SUBJECT: [Illegible]  
 [The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing various items and their status.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05862 Item 8 Film G400 240/68 1st									
05866									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First ETTA Middle MCGHEE Last HORTON					Month 4 Day 27 Year 68			10:30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		6/20/85		82 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MISSOURI		U.S.A.				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
OLNEY		MONTGOMERY GENERAL HOSP.		HOUSEWIFE		HOMEMAKING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		MONTGOMERY		SILVER SPRING				3314 CHISWICK COURT	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First WILLIAM Middle MCGHEE Last			First HENRIETTA Middle FRISBIE Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
UNKNOWN			None		Daug. Virginia Hedenkam Address Same as Item 13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic - Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 months.</u> <u>years.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>68</u> , to <u>Apr.</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>4/26/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <u>Richard A. Yates MD</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/27/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>RICHARD A. YATES</u>					22e. ADDRESS <u>OLNEY, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial-transit 4-29-68				Elmwood Cemetery		Mexico, Missouri			
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE MAY 01 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>FRANK NMN HOWARTH</b>						2a. DATE OF DEATH Month <b>APRIL</b> Day <b>30</b> Year <b>68</b>			2b. HOUR <b>6:00</b> AM		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>1-1-87</b>			6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>AMER</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONT.</b> Md.					
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH. SAN. &amp; HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MACHINIST</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>MFG Co.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Fla. Ark.</b>			13b. COUNTY <b>Montgomery</b>			13c. STREET AND NUMBER <b>1505 Live Oak Dr.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First <b>Lewis</b> Middle <b>Howarth</b> Last <b>Stotts</b>			15. MOTHER'S MAIDEN NAME First <b>Zebudah</b> Middle <b>Stotts</b> Last <b>Stotts</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>020-01-2508</b>			17. INFORMANT <b>Thomas Howarth</b> Address <b>1505 Live Oak Dr. Silver Spring</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4129 IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bleeding gastric ulcer.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>3 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4200</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>8/10</b> , 19 <b>67</b> , to <b>4/30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/29</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Harry N. Carlton, MD</b> DEGREE <b>MD</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 30, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>HARRY N. CARLTON</b>						22e. ADDRESS <b>8811 Colesville Rd, Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>St. Petersburg, Florida</b>				
24. FUNERAL DIRECTOR <b>Green Carter Clin Corp</b> ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>						25a. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			

1. Name of the plant or animal ...  
2. Date of collection ...  
3. Locality ...  
4. Collector ...  
5. Description of the specimen ...  
6. Remarks ...  
7. Name of the person to whom the specimen was sent ...  
8. Date of shipment ...  
9. Name of the person who received the specimen ...  
10. Remarks ...

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VR A15 (4)  
30M REV. 1/68

05864										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05868									
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR									
ERNESTINE L. HOWERTON										APRIL 26 1968										5:07 AM									
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH NOV. 21, 1910			6. AGE (In years last birthday) 57 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) Indiana			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md.																				
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER APT 720 4977 BATTERY LANE																	
14. FATHER'S NAME First Middle Last Theodore Lochke			15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Helke			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. Unknown			17. INFORMANT Husband Paul W. Howerton			Same as Item 13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinomatosis, massive</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Primary adenocarcinoma, ascending colon</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 5 mo 6 mo																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1530																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																										
22a. I certify that (I) (this hospital) attended the deceased from Dec 1967, to April 26, 1968, that (I) (we) last saw the deceased alive on 4/25/68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Edward S. Witowski, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 4-26-68																			
22d. PHYSICIAN'S NAME (Type) EDWARD S. WITOWSKI, Jr.			22e. ADDRESS Suite 100 8218 Wisconsin Ave, Bethesda Md. 20014																										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-29-68			23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.			23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland																				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland			ADDRESS			25a. REC'D BY REGISTRAR DATE APR 29 1968			25b. REGISTRAR'S SIGNATURE Charles Judge																				

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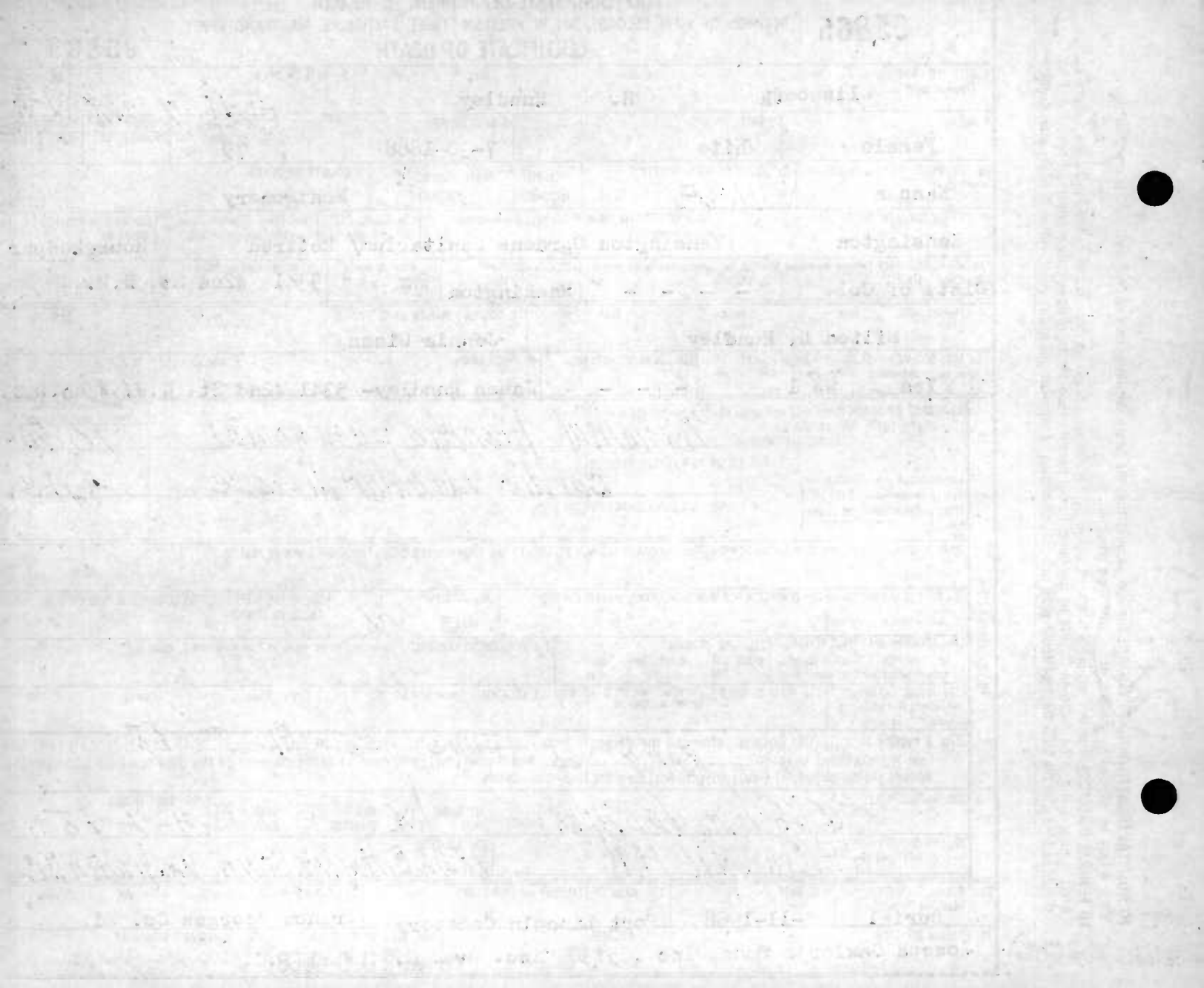
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
05865 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
05869									
1. DECEASED NAME (Type or print) <b>Elizabeth</b>			First <b>H.</b> Middle <b>H.</b> Last <b>Hundley</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1968</b>		2b. HOUR <b>1:50 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-30-1888</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kensington Gardens Sanitarium</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeper</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Dist. of Col.</b>		13b. COUNTY <b>- - - -</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5341 42nd St. N.W.</b>	
14. FATHER'S NAME First <b>Milton B.</b> Middle <b>Hundley</b> Last <b>Hundley</b>			15. MOTHER'S MAIDEN NAME First <b>Jennie</b> Middle <b>Glass</b> Last <b>Glass</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		(If yes give war or dates of service) <b>WW 1</b>		16b. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT Address <b>James Hundley- 5341 42nd St. N.W. Wash. D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal broncho pneumonia</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardio vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 yrs.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>58</b> , to <b>April 7</b> , 19 <b>68</b> , that (I) (we) lost the deceased on <b>April 7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>E.E. Quagley M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-7-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>E.E. Quagley M.D.</b>		22e. ADDRESS <b>1822 Biltmore St NW Washington DC</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-11-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisc. Ave.</b>		25a. REC'D BY REGISTRAR <b>APR 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05866

CERTIFICATE OF DEATH

05870

1. DECEASED-NAME (Type or print)			First George	Middle Matthew	Last Ingram	2a. DATE OF DEATH Month Day Year April 25, 1968			2b. HOUR A 7:35 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 5, 1919		6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Chemical					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE West Virginia		13b. COUNTY ✓		13c. CITY OR TOWN South Charleston		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3706 Washington Street			
14. FATHER'S NAME First Middle Last William Matthew Ingram			15. MOTHER'S MAIDEN NAME First Middle Last Edith Virginia Lett								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Md. 20014						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congenitally malformed valve</u> 746.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholelithiasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 years 5 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7545											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 17</u> , 19 <u>68</u> , to <u>April 25</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 25</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ferid Murad M.D.</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 25 April 1968				
22d. PHYSICIAN'S NAME (Type) Ferid Murad, M. D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-29-68		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) SO CHARLESTON WEST VA					
24. FUNERAL DIRECTOR <u>Wm. Chambers Co</u>					ADDRESS <u>1400 Chapin St NW</u>		25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

100-840

UNITED STATES DEPARTMENT OF JUSTICE

ATTORNEY GENERAL

100-840



TO THE HONORABLE ATTORNEY GENERAL  
WASHINGTON, D. C.  
FROM THE DIRECTOR, FBI  
SUBJECT: [Illegible]  
[The body of the letter contains several paragraphs of text that are mostly illegible due to fading and poor scan quality. Some words like 'subject', 'information', and 'report' are faintly visible.]

100-840  
[Illegible text in the right margin, possibly a file number or reference code.]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05867

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05871

1. DECEASED-NAME (Type or Print) <i>Ben</i>			First Middle Last <i>Tsquithe</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>April 28 1968</i>			2b. HOUR <i>8:05</i> M.										
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>5/16/28</i>		6. AGE (In years last birthday) <i>39</i> YES		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD <i>4/28</i> Month Day Year <i>1968</i>		2d. HOUR <i>8:05</i> M.					
7a. BIRTHPLACE (State or foreign country) <i>New York</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Montgomery</i> Md.							
10. CITY OR TOWN OF DEATH <i>Rockville</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>PROGRAMER</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>CYBERNETICS</i>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>				13b. COUNTY <i>Mont</i>				13c. CITY OR TOWN <i>Rockville</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER <i>10500 Rockville Pike</i>			
14. FATHER'S NAME <i>Robert</i>				First Middle Last <i>Tsquithe</i>				15. MOTHER'S MAIDEN NAME <i>Evelyn</i>				First Middle Last <i>Leffowitz</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				(If yes give war or dates of service) <i>Army</i>				16b. SOCIAL SECURITY NO.				17. INFORMANT <i>Bruce Tsquithe</i>				ADDRESS <i>7402 Bay Parkway Bethesda N.Y.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <i>Myocardial infarction, recent and remote</i>												<i>24 hrs.</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary arteriosclerosis with occlusion</i>												<i>Years.</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>John M. Ball</i>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED <i>4/29/68</i>							
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>4/29/68</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Mount Carmel</i>				23d. LOCATION (City or town) (County) (State) <i>Elmont, N.Y.</i>							
24. FUNERAL DIRECTOR <i>Sal Levinson</i>						ADDRESS <i>6010 Reservoir Rd. Baltimore</i>						25a. REC'D BY REGISTRAR <i>MAY 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

100-100000

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-100000

IDENTIFICATION

PERSONNEL

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

05868

05872

1. DECEASED-NAME (Type or print) <b>Bessie</b>			First <b>None</b>			Middle <b>Itzkowitz</b>			Last			2a. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>7:30</b> M <b>PM</b>					
3. SEX <b>Female</b>			4. RACE <b>white</b>			5. DATE OF BIRTH <b>12-28-79</b>			6. AGE (In years last birthday) <b>88</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>American</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.											
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanitarium &amp; Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Washington D.C.</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>WASHINGTON</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>6676 Georgia Avenue NW</b>								
14. FATHER'S NAME First <b>max</b> Middle <b>Sinkler</b> Last <b>Braine</b>			15. MOTHER'S MAIDEN NAME First <b>Switkes</b> Middle <b>Switkes</b> Last <b>Switkes</b>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>			17. INFORMANT <b>Records Washington Sanitarium &amp; Hospital</b> Address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE, PULMONARY EMBOLISM</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBROVASCULAR THROMBOSIS, RIGHT HEMIPLEGIA</b> DUE TO, OR AS A CONSEQUENCE OF <b>HYPERTENSIVE AND ARTERIOSCLEROTIC</b> (c) <b>CARDIOVASCULAR AND CEREBROVASCULAR DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>2 WEEKS</b> <b>30 YEARS</b>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>443X</b>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>64</b> , to <b>APRIL 9</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <b>Robert L. Krichmar MD</b>			DEGREE <b>MD</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>APR 9 1968</b>											
22d. PHYSICIAN'S NAME (Type) <b>ROBERT L. KRICHMAR MD</b>			22e. ADDRESS <b>7733 ALASKA AVENUE NW WASHINGTON D.C. 20012</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>4-11-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Geo. WASH. Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>THATTSVILLE MD</b>											
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>			ADDRESS <b>4215-9th St. NW</b>			25a. REC'D BY REGISTRAR DATE <b>APR 16 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											



18862

OFFICE OF THE SECRETARY OF THE ARMY

18862

TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report.]

RECEIVED  
[Illegible text in the right margin, possibly a date or reference number.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner Has Been Notified and Approves

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Carlotta B. Jackson</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1968</b>			2b. HOUR <b>6<sup>45</sup> P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>Feb. 1, 1903</b>		6. AGE (In years lost birthday) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>10203 Brooknoor Drive</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>10203 Brooknoor Drive</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b>J.</b> Last <b>Bieber</b>			15. MOTHER'S MAIDEN NAME First <b>Lisetta</b> Middle <b>Huth</b> Last <b>Huth</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)				
16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mr. Frank R. Jackson</b> Address <b>10203 Brooknoor Drive Silver Spring, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMED</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Y201</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 12, 1968</b> to <b>April 11, 1968</b> , that (I) (we) last saw the deceased alive on <b>March 12, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Bernard A. Fitzgerald</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 11, 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Bernard A. Fitzgerald</b>				22e. ADDRESS <b>217 Univ. Blvd. E., Silver Spring, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>				
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>				ADDRESS <b>8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
						17 1968				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First <b>WILLIAM</b>			Middle <b>-</b>			Last <b>JACKSON</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>4</b> Day <b>2</b> Year <b>1968</b>			2b. HOUR <b>12 NOON</b>		
3. SEX <b>MALE</b>		4. RACE <b>COLORED</b>		5. DATE OF BIRTH <b>1889</b>		6. AGE (In years last birthday) <b>78 RS.</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>2</b> Year <b>1968</b>			2d. HOUR <b>12 NOON</b>		
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b>								
10. CITY OR TOWN OF DEATH <b>BRINKLOW</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA MONTGOMERY GENERAL, OLNEY</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BRINKLOW</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Box 23</b>							
14. FATHER'S NAME First <b>UNKNOWN</b>					15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MEDICAL RECORD DEPT.</b>				ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>Belden R. Reap</b>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>APRIL 2, 1968</b>					
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town, or County) <b>Rockville, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Apr. 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Montg. Co Home Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montg. Md.</b>									
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 9 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

4530

2551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Baby Boy</i>		First	Middle	Lost	2a. DATE OF DEATH Month <i>4</i> Day <i>3</i> Year <i>68</i>		2b. HOUR M <i>AM</i>
3. SEX <i>Male</i>		4. RACE <i>Color</i>		5. DATE OF BIRTH <i>4/3/68</i>		6. AGE (In years last birthday) YRS. <i>—</i> MONTHS <i>—</i> DAYS <i>—</i>	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>James</i>		First	Middle	Lost	15. MOTHER'S MAIDEN NAME <i>Barbara</i>		First <i>Joppy</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> <i>7762</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Immaturity</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Immaturity</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>776X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/3/68</i> , 19 <i>68</i> , to <i>4/3/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/3/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Vincent L. O'Donnell Md</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>4/4/68</i>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS <i>5415 W. Cedar Rd Bethesda Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Suburban Hospital</i>		23d. LOCATION (City or Town) (County) (State) <i>Bethesda-Montgomery-Md.</i>	
24. FUNERAL DIRECTOR <i>Mrs. Amelia C. Carter, Administrator</i>				25a. REC'D BY REGISTRAR DATE <i>APR 9 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

VR A 15 (4)  
30M REV. 1-68

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		2b. HOUR
RICHARD		W.	JORGENSEN	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4 13 1968		2b. HOUR 8:45 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR
MALE	WHITE	MARCH 31, 37	31 YRS.			APRIL 13, 1968	6:45 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Washington, D.C.		U.S.A.				MONTGOMERY	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		5014 Elm Street Apt 5		Data Processing		NIH - Govt	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		MONTGOMERY		BETHESDA		5014 ELM STREET	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
William F. Jorgensen					Blanche Richard		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Father		Same as Item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 4109		Coronary Occlusion. Left Ant.		Sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Coronary Arterio Sclerosis. Minimum.		4 years			
		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		JOHN G. BALL		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		APRIL 13, 1968	
				ADDRESS (Street, city, town, or county)		Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
4-16-68		Burial		Gate of Heaven		Silver Spring, Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY		Bethesda, Maryland		DATE APR 17 1968		Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

TO THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D. C.

FROM THE

REVENUE

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF REVENUE, WASHINGTON, D. C.

RECEIVED

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF REVENUE, WASHINGTON, D. C.

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UNITED STATES DEPARTMENT OF THE INTERIOR

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UNITED STATES DEPARTMENT OF THE INTERIOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05873		CERTIFICATE OF DEATH						05876			
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
SOPHIA		KACABA		Apr. 18-68		11 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		May 16-1898		89 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Poland		XXX Poland				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Springs		1724-Priscilla Dr		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Montgomery		Silver Springs		NO <input type="checkbox"/>		1724-Priscilla Dr			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Unknown								Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Md. Address		Hillcrest High t	
no						Virginia White		2115-Jameson St SE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										4 days	
1929 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <u>Glioblastoma</u>										2 months	
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
1939											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-6-</u> , 19 <u>68</u> , to <u>4-18-</u> , 19 <u>68</u> , that (I) <u>was</u> lost saw the deceased alive on <u>4-16-</u> 19 <u>68</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) <u>not</u> view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. CITY OR TOWN		22g. STATE	
<u>Sydney Leventhal, M.D.</u>		Apr. 18-68		Sydney Leventhal M.D.		9210-Colesville Rd		Silver Springs		Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Apr. 22-68		Masonic Cemetery		Shinnston, West Va.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Simmons Bros		Wash DC		DATE		APR 22 1968					
Simmons Bros 1661 Good Hope RD SE											

6784

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05874		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05877					
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR			
First Middle Last NATHAN NMN KATZ						Month Day Year April 25 1968		5 <sup>05</sup> A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR			
MALE		WHITE		8/2/28		73 <del>72</del> YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington San + Hosp.		Retired		SALESMAN FOOD					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Montgomery		HYATTSVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8201 NEWHAMPSHIRE AVE			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)							
Abraham		Katz		Olga		16b. SOCIAL SECURITY NO. 578-09-6122					
						17. INFORMANT MR. HYMAN KATZ, Address 11 SLADE AVE. APT. 44 #8					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>arteriosclerosis + Hypertensive Heart Disease</u>											
2509 DUE TO, OR AS A CONSEQUENCE OF <u>Dissecting Aortic Aneurysm</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dissecting Aortic Aneurysm</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
260x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from April 19 68 to 4-25 19 68, that (I) (we) last saw the deceased alive on 4-24 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
Boris Rabkin MD		4-25-68		Boris RABKIN		1019 Union Blvd + 6A					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		4-26-68		BETH YEHUDA ANSHE KURLAND, BALTIMORE, MARYLAND							
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE					
SOL LEVINSON & BROS. INC.				Charles Judge		APR 29 1968					
6010 REISTERSTOWN ROAD, BALTO. 21215											



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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First <i>CORRIE</i>			Middle <i>MAE</i>			Last <i>KELLER</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>4 26 1968</i>			2b. HOUR <i>3:45</i> AM		
3. SEX <i>Fe.</i>		4. RACE <i>W.</i>		5. DATE OF BIRTH <i>Sept. 18 1917</i>		6. AGE (In years last birthday) <i>50 YRS.</i>		IF UNDER 1 YEAR MONTHS DAYS <i>7 8</i>		IF UNDER 24 HRS. HOURS MIN. <i></i>		2c. DATE PRONOUNCED DEAD Month Day Year <i>April 26 1968</i>			2d. HOUR <i>3:10</i> AM		
7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Rockville</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>13907 Travilah Rd.</i>								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>				13c. CITY OR TOWN <i>Rockville</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>13907 Travilah Rd.</i>			
14. FATHER'S NAME First Middle Last <i>William F Harrison</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Leona Edward</i>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16b. SOCIAL SECURITY NO. <i>234-01-7669</i>				17. INFORMANT <i>Mitchell C. Keller</i>				13907 ADDRESS <i>Travilah Rd. Rockville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pancreatitis, acute, hemorrhagic</i> <i>5770</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 hr.</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>5870</i>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>John G. Ball</i>				EXAMINER'S NAME (Type) <i>John G. Ball</i>				BETHESDA, Md.				22b. DATE SIGNED <i>4/26/68</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>4-29-1968</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Martinsburg W. Va.</i>					
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>				ADDRESS <i>1331 Rockville Pike Rockville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 29 1968</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

0523

MEMORANDUM FOR THE DIRECTOR

0523

FOR THE DIRECTOR

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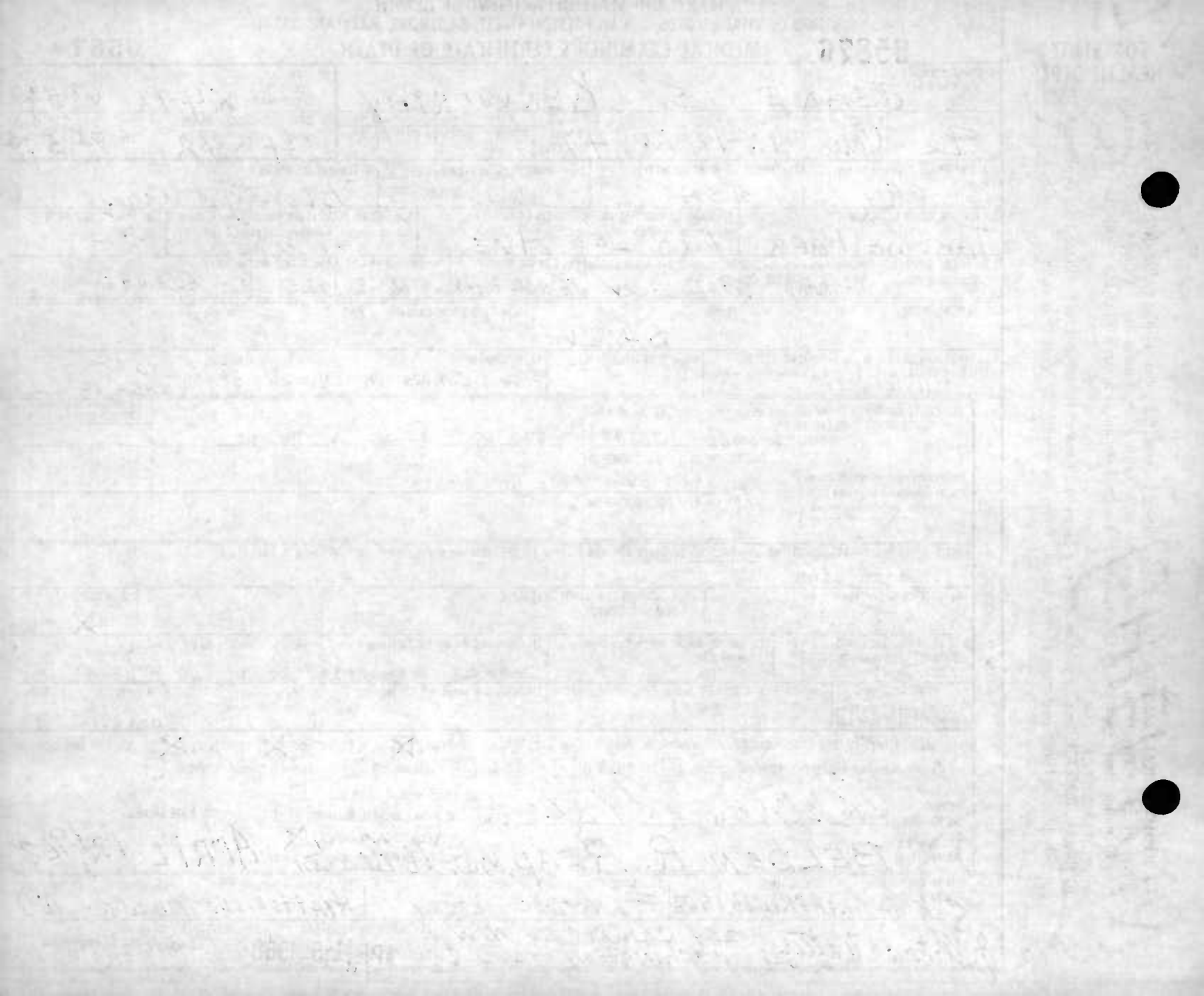
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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <b>JEANE S. KENWORTHY</b>						2a. DATE KNOWN OF DEATH <b>4-12</b>		2b. HOUR <b>68 545</b>		2c. DATE PRONOUNCED DEAD <b>4-12</b>	
3. SEX <b>Fe</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>12-12-20</b>		6. AGE (In years) <b>47</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>OHIO</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>125 LEE AVE.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>AT HOME</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>TAKOMA PARK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>125 LEE AVENUE</b>	
14. FATHER'S NAME First <b>SHREVE</b>				15. MOTHER'S MAIDEN NAME First <b>?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>				16b. SOCIAL SECURITY NO. <b>?</b>				17. INFORMANT <b>FRANCIS THURSTON KENWORTHY</b>			
								ADDRESS <b>6612 2ND ST WASH. 12, D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Asphyxiation due to Plastic Bag being</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <b>tied over face and head</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <b>last</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<b>Depression</b>											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased tied plastic bag over head</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>				21f. LOCATION Street or R.F.D. No. <b>Takoma Park Montg. Md</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Belden R. Reap</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>APRIL 12, 1968</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS <b>Takoma Park, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>				23b. DATE <b>APRIL 13, 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>FT LINCOLN Cemetery</b>			
23d. LOCATION (City or Town) <b>HYATTSVILLE</b>				23e. (County) <b>Prince Geo</b>				23f. (State) <b>MD</b>			
24. FUNERAL DIRECTOR <b>J. Arthur Walters</b>				25a. REC'D BY REGISTRAR <b>APR 15 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

05877

05880

1. DECEASED-NAME (Type or print) <i>WUNSZ</i>			First Middle Last			2a. DATE OF DEATH Month Day Year <i>April 21 1968</i>			2b. HOUR 5 <sup>00</sup> A M		
3. SEX <i>male</i>			4. RACE <i>Oriental</i>			5. DATE OF BIRTH <i>4/27/1892</i>			6. AGE (In years last birthday) <i>76</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>China</i>			7b. CITIZEN OF WHAT COUNTRY? <i>Perm. Resident USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Diplomat, etc.</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Montgomery</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Bethesda</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <i>S. S. King</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>KARN.</i>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO. <i>- -</i>			17. INFORMANT <i>Meinnee King Chun - daughter</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary arteriosclerosis, severed</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 3, 1961</i> to <i>April 21, 1968</i> , that (I) (we) last saw the deceased alive on <i>April 21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>George Sharpe MD</i>						DEGREE <i>MD</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <i>George Sharpe MD</i>						22e. ADDRESS <i>10400 Connecticut Ave, Kensington, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>April 23, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Mont. Co., Maryland</i>		
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5301 Wisc. Ave., Washington, D.C., 20016</i>						25a. REC'D BY REGISTRAR <i>APR 24 1968</i>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1  
30M REV 11/68

05878

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05881

1. DECEASED-NAME (Type or print) First Middle Last <b>KATHRYN E.M. NIRSCH</b>			2a. DATE OF DEATH Month Day Year <b>APRIL 16 1968</b>			2b. HOUR <b>3:30 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>April 5, 1888</b>		6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Colmar Manor Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Washington DC</b>		13b. COUNTY <b>Washington DC</b>		13c. CITY OR TOWN <b>Washington DC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2430 Penna Ave NW</b>	
14. FATHER'S NAME First Middle Last <b>Wm Courtney Magruder</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>-</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Wm C Shudrow Poolsville, Md</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH</b> <b>151.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DEBILITY</b> (b) <b>151X</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>151X</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 MO</b> <b>1 YEAR</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>151X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (his hospital) attended the deceased from <b>2-12</b> , 19 <b>68</b> , to <b>4-16</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>4-15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>William Frank, M.D</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM FRANK, M.D.</b>					22e. ADDRESS <b>11125 ROCKVILLE PIKE, ROCKVILLE</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 19, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b> ADDRESS					25a. REC'D BY REGISTRAR <b>APR 18 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY DR. JOHN ROGERS FOR "RELEASED BY CORONER"

MEDICAL CERTIFICATION

05879		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05882					
1. DECEASED-NAME (Type or print) First Middle Last HAROLD JAMES KISSENBERGER				2a. DATE OF DEATH Month 4 Day 20 Year 68		2b. HOUR 4 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 4/8/06		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SERVICE MAN		12b. KIND OF BUSINESS OR INDUSTRY Wash. Gas Light			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11514 Regnid St. DR	
14. FATHER'S NAME First Middle Last John Kissenberger		15. MOTHER'S MAIDEN NAME First Middle Last Crawford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT 11514 REG NID. DR Address: WHEATON wife, Kathleen KISSENBERGER MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary disease years DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 Emphysema - diabetes									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from AUG 31, 1964, to April 20, 1968, that (I) (we) last saw the deceased alive on 4/19/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles Farwell, M. D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/20/68			
22d. PHYSICIAN'S NAME (Type) Charles Farwell, M. D.		22e. ADDRESS 11406 Viers Mill Rd., Wheaton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/26/1968		23c. NAME OF CEMETERY OR CREMATORY FOREST OAK		23d. LOCATION (City or Town) (County) (State) CATHERSBURG MD			
24. FUNERAL DIRECTOR W. W. Conner General Home MD		24a. ADDRESS 8465 GEORGIA AVE SILVER SPRING MD		24b. REC'D BY REGISTRAR APR 24 1968		24c. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1/68

05880		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05883				
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year		2b. HOUR MIN		
Betty H. A. Kohler						April 13 68		107 23		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		W		2/11/26		42		YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Ohio		U.S.A.				Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Suburban			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Montgomery Rockville						6 Cleveland Court	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Harry Hawby			Carol Foster							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
No						Husband Albert F. Kohler			Same as Item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Embolism Right Mif Cerebral Artery 3 days DUE TO, OR AS A CONSEQUENCE OF (c) Mural Thrombi Left Ventricle Idiopathic Myocardopathy 2 days								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Multiple Organ Emboli										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
				3/15/68 4/14/68						
22a. I certify that (I) (this hospital) attended the deceased from 3/15/68, to 4/14/68, that (I) (we) last saw the deceased alive on 4/14/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert C. Macon				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/15/68				
22d. PHYSICIAN'S NAME (Type) ROBERT C. MACON				22e. ADDRESS 809 Viers Mill Rd, Rockville Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		4-17-68		Cedar Hill Crematory		Suitland, Maryland				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



OFFICE OF THE ATTORNEY GENERAL

CHICAGO, ILL.

*[Faint, illegible handwritten text, possibly a signature or address]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Cleared with Medical Examiner

05881		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05884	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Edna E. LaGrone			2a. DATE OF DEATH Month Day Year April 16, 1968			2b. HOUR 8:40	
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 26, 1909		6. AGE (In years last birthday) 58 YRS.	
7a. BIRTHPLACE (State or foreign country) Oklahoma		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5000 McCall St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 5000 McCall St.		14. FATHER'S NAME First Middle Last George Humbard		15. MOTHER'S MAIDEN NAME First Middle Last Maranda Frances Stone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Address R.B. Cranfill 5000 McCall St., Rock			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH @ 5 months. @ 5 years.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>@ Dec.</u> , 19 <u>67</u> , to <u>April 16</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>@ 4/11</u> 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.							
22b. SIGNATURE <u>Lewis N. Cahill</u> M.D. DEGREE		22c. DATE SIGNED <u>April 16, 1968</u>		22d. PHYSICIAN'S NAME (Type) <u>LEWIS N CAHILL</u>			
22e. ADDRESS <u>5411 W. CEDAR LN. BETHESDA, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL <u>burial</u>		23b. DATE <u>4-20-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gladewater Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Gladewater Texas</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR DATE <u>APR 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR		
			Ruth	Emma	La Pointe			<input checked="" type="checkbox"/> X	4	28	19 68	9:50 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
Female	White	7-10-1904	63 YRS	MONTHS		DAYS		4		28	19 68	9:50 A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maine		U.S.A.				Montgomery		Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Wheaton Md.			12027 Livingston St.			Auto. Dietian			Hospital				
13a. USUAL RESIDENCE (Where deceased lived, if admission)			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER				
Maryland			Montgomery Wheaton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12027 Livingston St.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
			Lyman		Staples				Emma		Tickering		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			12027 Livingston St.				
no			002-20-6278			Mrs. Geraldine Twombly Wheaton, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Arteriosclerotic Heart Disease													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4201													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. P.M.		19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED					
EXAMINER'S NAME (Type)		BELDEN R. REAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		4/28/1968					
						ADDRESS (Street, City or town, county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)							
Cremation		4-28-68		Fort Lincoln Crematory		Prince George, Co., Maryland							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John W. Lee 8434 Georgia Avenue						DATE		MAY 1 1968					
Warner E. Pumphrey, Inc. Silver Spring, Md.													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>First</b> <i>Jennie</i> <b>Middle</b> <i>A.</i> <b>Last</b> <i>LATINO</i>						2a. DATE OF DEATH Month <i>April</i> Day <i>2</i> Year <i>1968</i>			2b. HOUR <i>7A</i> MIN <i>M</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>MARCH 16 1891</i>		6. AGE (In years last birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>ITALY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i> Md.					
10. CITY OR TOWN OF DEATH <i>Kensington</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>KENSINGTON GARDENS SANITARIUM</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>				13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4815 41st St N.W.</i>	
14. FATHER'S NAME <b>First</b> <i>Joseph</i> <b>Middle</b> <i>Attardi</i> <b>Last</b>						15. MOTHER'S MAIDEN NAME <b>First</b> <i>Rose</i> <b>Middle</b> <i>Coletta</i> <b>Last</b> <i>ATTARDO</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>027-03 2286</i>		17. INFORMANT Address <i>Jennie M. Latino see # 13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>410.0</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>420.1</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes mellitus; Aural Gargore 7.3 hrs; Essential Hypertension</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1955 1962</i> , to <i>April 2, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 30 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Bertram F. Schaefer MD</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>April 2, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>Bertram F. Schaefer MD</i>						22e. ADDRESS <i>1780 Mass. Ave. N.W. Wash. D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i>				23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Jos. Gawler's 5130 Wisconsin Av., Wash. D.C.</i>						25a. REC'D BY REGISTRAR DATE <i>APR 5 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



03330

RECEIVED

03330

RECEIVED

03330

RECEIVED

RECEIVED



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print) <i>Jack Leuen</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH Day Year <i>Apr 5 1968</i>		2b. HOUR <i>4:15</i> M <i>PM</i>		2c. DATE PRONOUNCED DEAD Month Day Year <i>Apr 5 1968</i>			
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>9/9/21</i>		6. AGE (in years last birthday) <i>46</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>South Carolina</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Music Contractor</i>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>				13b. COUNTY <i>Mont</i>				13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>9323 Chesin Dr</i>	
14. FATHER'S NAME First Middle Last <i>James J Leuen</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>Ida Mae Pope</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes Army</i>				16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Wife Helen Leuen</i>				ADDRESS <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis acute and hemoperitoneum</i> <i>816.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>secondary to trauma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>secondary to automobile accident</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>8234</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>8:15 PM 3-28 1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Lost control of car, &amp; struck a house swerved off highway</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>			21f. LOCATION Street or R.F.D. No. City or Town County State <i>Bethesda Montgomery Md</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>April 5, 1968</i>					
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>4-8-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>					
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>						25a. REC'D BY REGISTRAR <i>APR 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>					

[Faint, mostly illegible text covering the main body of the document, possibly a letter or report.]

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-19-68 mt 222 1111 401 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05885

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05888

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
ERNEST DAVID LEWIS						Month Day Year			1968 10 18		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
MALE	WHITE	2-14-68	YRS. 26	MONTHS 2	DAYS 6	HOURS	MIN.	Month Day Year			1968 10 18
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD		U.S.A.				MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK			WASH. SAN & Hosp.			NONE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MD			MONT.		T. P.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		107 ELM AVENUE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
CHARLES LEWIS			SHIRLEY THACKER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
NO			NONE		HOSPITAL			RECORD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 485X Acute bronchial pneumonia with marked atelectasis										1-2 days	
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
491X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL			APR. 24, 1968		SUMMERS CEMETERY		APPALACHIA. VIRGINIA				
24. FUNERAL DIRECTOR				25. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
J. Arthur Walters, Takoma Funeral Home, 254 Carroll St. N.W. D.C.				DATE Apr 23 1968				Charles Judge			

88321

HEAD NO 3 FORMED PROHIBITION PAY 100

88321

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1



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

05886

05889

1. DECEASED-NAME (Type or print) First Middle Last <b>ANNA ELIZABETH LINGLE</b>			2a. DATE OF DEATH Month Day Year <b>APRIL 12 1968</b>		2b. HOUR 5 <sup>56</sup> PM
3. SEX <b>FEMALE</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>May 30, 1892</b>		6. AGE (In years last birthday) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON SAN. &amp; Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>Takoma Park</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>1108 Linden Ave Apt 202</b>	
14. FATHER'S NAME First Middle Last <b>John F. GERHOLD</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>LORENA TAYLOR</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>NO</b>	16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>HOSPITAL RECORDS.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction vs CVD</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF <b>as CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>aging process</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201 Emphysema Hypertension, Chemo</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1968</b> , to <b>April 12, 1968</b> , that (I) (we) lost saw the deceased alive on <b>April 12, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Russell C. Bufalino, MD</b> DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>April 13, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Russell C. Bufalino, MD</b>		22e. ADDRESS <b>1429 University Blvd W. Silver Spring</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>April 16-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington DC</b>	
24. FUNERAL DIRECTOR <b>Arthur Walters</b>		ADDRESS <b>154 General St</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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TO THE ORDER OF  
PAY TO THE ORDER OF  
FOR DEPOSIT ONLY  
THIS CHECK IS NOT VALID  
UNLESS IT IS COUNTERSIGNED  
BY THE ISSUING OFFICE  
AND THE SIGNATURE OF THE  
ISSUING OFFICE IS  
VERIFIED BY THE  
RECEIVING OFFICE



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>James M Lord</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>24</i> Year <i>1968</i>			2b. HOUR <i>11:30</i> M			
3. SEX <i>Male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>11/21/78</i>		6. AGE (In years last birthday) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS <i>8</i> DAYS <i>1</i> HOURS <i>1</i> MIN	
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>ACCOUNTANT</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10401 Glenview Lane</i>	
14. FATHER'S NAME First <i>Ralph</i> Middle <i>B</i> Last <i>Lord</i>			15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>(Walter)</i> Last <i>(Walter)</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>086-07-4463A</i>		17. INFORMANT <i>Wife - Mrs. Mary Lord</i>		Address <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4109</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>4201</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pulmonary Tuberculosis - non infective</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/23</i> , 19 <i>67</i> , to <i>4/24</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4/24</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Michel M Healy MD</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/24/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Michel M HEALY MD</i>		22e. ADDRESS <i>5441 W. Cedar La, Bethesda, Md 20014</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 26, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, P.G. Co., Maryland</i>			
24. FUNERAL DIRECTOR <i>Joseph Hawker's Sons</i>		ADDRESS <i>Washington, D.C.</i>		25a. REC'D BY REGISTRAR <i>APR 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/15/03 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>ROSE</u>			First <u>A</u> Middle <u>Lydon</u> Last			2a. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>68</u>			2b. HOUR <u>12:30</u> P M		
3. SEX <u>Female</u>			4. RACE <u>White</u>			5. DATE OF BIRTH <u>5-7-97</u>			6. AGE (In years last birthday) <u>70</u> YRS.		
7a. BIRTHPLACE (State or foreign country) <u>Ill.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>MONTGOMERY</u> Md.		
10. CITY OR TOWN OF DEATH <u>Silver Spring, Md.</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hosp.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md</u>			13b. COUNTY <u>Montgomery</u>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <u>4050 Adams Drive</u>		
14. FATHER'S NAME First <u>Hensel</u> Middle <u></u> Last <u></u>			15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u></u> Last <u></u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>354-22-6460</u>		
17. INFORMANT <u>James C. Schmidt, Sr.</u>			Address <u>4050 Adams Drive Silver Spring, Md.</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute anteroseptal myocardial infarction</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombosis anterior descending left coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>4201</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-17, 1968</u> to <u>4-20, 1968</u> , that (I) (we) last saw the deceased alive on <u>4-20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Jason Geiger, M.D.</u>			DEGREE <u>M.D.</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>4-20-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>JASON GEIGER, M.D.</u>			22e. ADDRESS <u>800 PEARLINE DRIVE SILVER SPRING, MD.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>April 23, 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Chicago Illinois</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						Address <u>34 Georgia Ave. Silver Spring, Md.</u>			25a. REC'D BY REGISTRAR <u>J. J. Jones</u> DATE <u>APR 23 1968</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Catherine Josephine Maher</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>4</i> Year <i>1968</i>			2b. HOUR <i>3:45 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>March 19, 1881</i>		6. AGE (In years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>408 Lanark Way</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Penn.</i>		13b. COUNTY <i>Philadelphia Philadelphia</i>		13c. CITY OR TOWN <i>Philadelphia</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4203 Disston Street</i>	
14. FATHER'S NAME First Middle Last <i>Christopher Gercke</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Catherine Shea</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>John C. Maher</i>		Address <i>Silver Spring Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Insufficiency</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221</i> <i>Chronic congestive heart failure</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <i>(did not)</i> attended the deceased from <i>Jan</i> , 19 <i>68</i> , to <i>April</i> , 19 <i>68</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>April 2</i> , 19 <i>68</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> <i>(did)</i> <i>(did not)</i> view the body after death.						22b. SIGNATURE <i>Bernard A. Fitzgerald</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <i>4-4-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Bernard A. Fitzgerald</i>		22e. ADDRESS <i>217 Univ. Blvd. E., Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-8-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Dominics Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Philadelphia, Pennsylvania</i>			
24. FUNERAL DIRECTOR <i>Clark E. Wisor</i>		ADDRESS <i>8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR DATE <i>APR 9 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
Warner E. Pumphrey, Inc., Silver Spring, Md.									

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Capital Projects Fund

Page 1 of 1

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John C. Lammert, Mayor of Houston

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) First Middle Last <i>Baby Girl MAHONEY</i>		2a. DATE OF DEATH Month Day Year <i>4 16 68</i>		2b. HOUR <i>4:18A.M.</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>4-15-68</i>	6. AGE (In years lost birthday) YRS. <i>23</i>	IF UNDER 1 YEAR MONTHS DAYS <i>23</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>13817 Traveller Rd.</i>
14. FATHER'S NAME First Middle Last <i>Will Smith</i>	15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Helen Williams</i>	16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. <i>776 2</i>		17. INFORMANT <i>Mary Helen Williams</i> Address <i>Mother-same item # 15</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory Distress Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chemotherapy +</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <i>773.5</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>4/15/68</i> , 19____, to <i>4/16/68</i> , 19____, that (I) (we) last saw the deceased alive on <i>4/15/68</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Vincent L. O'Donnell MD</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/16/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Vincent L. O'Donnell</i>		22e. ADDRESS <i>5415-W. Adams La Beth. Md</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>4/18/68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR <i>TYSON WHEELER</i>		ADDRESS <i>1331 Rockville Pike Rockville, Maryland</i>		25a. REC'D BY REGISTRAR <i>APR 19 1968</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Eugene Lenard Mason						MAY 3 1968		10:15 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
M.	Colored	12/22/1914	53 YRS.	MONTHS DAYS		HOURS MIN		April 3 1968		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville			10401 Sevenlocks Rd.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Rockville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10401 Sevenlocks Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Eugene Lenard Mason Sr.			Leita Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Throat with Metastases</u>									Years	
149X DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
148X										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>John B. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED		
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				4/4/68		
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
				ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		Apr. 7, 1968		Moses Cemetery		Cabin John Montg, Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert L. Saunders				Rockville, Md.		DATE APR 9 - 1968		Charles J. J. J.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

05892		05895					
1. DECEASED-NAME (Type or print) First Middle Last <b>Mary Dugan Mattare</b>				2a. DATE OF DEATH April Month 16 Day 68 Year		2b. HOUR 4:55A M	
3. SEX Female		4. RACE white		5. DATE OF BIRTH 2-28-1886		6. AGE (In years lost birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) WASH DC		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH md Silver Spring (Colesville)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairland Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 39d Rosemary ST.		14. FATHER'S NAME First Middle Last Patrick Dugan		15. MOTHER'S MAIDEN NAME First Middle Last Horna Feeney		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No	
16a. YES, NO, or (unknown)		16b. SOCIAL SECURITY NO. 218-56-5256		17. INFORMANT Husband Dr. John J. Mattare		Address Same as Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> Unknown immediate cause 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction? DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Chest Congestion							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-27-1965, to 4-16-1968, that (I) (we) last saw the deceased alive on 4-16-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R.C. Buzalino (for Dr. Fitzgerald)		22c. DATE SIGNED Apr 17 1968		22d. PHYSICIAN'S NAME (Type) R.C. Buzalino M.D.			
22e. ADDRESS 1429 University Blvd W.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE 4-18-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05893		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05896	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <i>Leva Lloyd McClung</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>20</i> Year <i>1968</i>		2b. HOUR <i>645 P. M.</i>
3. SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>November 4, 1881</i>		6. AGE (In years last birthday) <i>86</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Montgomery</i>		Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>9306 Wire Avenue</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife - own home</i>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spr.</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>9306 Wire Avenue</i>			
14. FATHER'S NAME First <i>John</i> Middle <i>Lloyd</i> Last <i>Shawlin</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Shawlin</i> Last <i>Shawlin</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>213-48-1557</i>		17. INFORMANT <i>Mrs. Virginia Faron</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis, Acute</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Arterio-sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial Infarction (old) Multiple</i> (c) <i>Cerebral Thrombosis - mild</i> <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		PROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>Undetermined</i> <i>1963</i> <i>1966-1967</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Osteo-arthritis, severe, multiple joints - Generalized arterio-sclerosis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>September 11, 1955</i> , to <i>Apr. 20, 1968</i> , that (I) (we) last saw the deceased alive on <i>Apr. 17, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>George L. Ball</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>April 21, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>George L. Ball</i>		22e. ADDRESS <i>10620 Georgia Avenue Silver Spring, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 24 '68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mountain View</i>	
23d. LOCATION (City or Town) (County) (State) <i>Charleston, West Virginia</i>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>24 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 23 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05894

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1. DECEASED-NAME (Type or print) <b>ALICE FRANCES McCORMICK</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>4:54 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>MARCH 18, 1897</b>		6. AGE (In years last birthday) <b>71</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>328 BROADWOOD</b>		14. FATHER'S NAME First Middle Last <b>Patrick J. Collins</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Annie Duffy</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>	
16b. SOCIAL SECURITY NO. <b>075-32-8244</b>		17. INFORMANT <b>Daughter Frances Thatch</b>		Address <b>Same as above</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>260X</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 &amp; 1/2 hrs</b>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1, 1951</b> , to <b>8 APR 1968</b> , that (I) (we) last saw the deceased alive on <b>8 APR 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/9/68</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN M. WYMAN M.D.</b>	
22e. ADDRESS <b>7801 NORFOLK AVE., BETHESDA, MD.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/11/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>		24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1331 Rock Pike Rockville, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 11 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

05895		05898	
DECEASED-NAME (Type or print)		First Mark	Middle Andrew
		Lost McDonald	2a. DATE OF DEATH Month Day Year April 24 1968
3. SEX Male		4. RACE White	5. DATE OF BIRTH 18 August 1966
6. AGE (In years last birthday) YRS. 20		IF UNDER 1 YEAR MONTHS 6	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. CITY OR TOWN OF DEATH Bethesda		10. COUNTY OF DEATH Montgomery Md.	
11. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		12. CITY OR TOWN Greenbelt	
13. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET AND NUMBER 5917 Cherrywood Terrace	
15. FATHER'S NAME First Middle Lost Thomas McDonald		16. MOTHER'S MAIDEN NAME First Middle Lost Mary Schultz	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		18. SOCIAL SECURITY NO. None	
19. INFORMANT The Medical Records		Address The Clinical Center, Bethesda, Md. 20910	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral lobar pneumonia of unknown etiology</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myelogenous leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2043			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. LOCATION Street or R.F.D. No. City or Town County State	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
22a. I certify that (A) (this hospital) attended the deceased from February 6, 1968, to April 24, 1968, that (A) (we) last saw the deceased alive on April 24, 1968, and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Arthur S. Lanni MD		22c. DATE SIGNED 24 April 1968	
22d. PHYSICIAN'S NAME (Type) Institutes of Health, Bethesda, Md.		22e. ADDRESS Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-26-68	
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.		23d. LOCATION (City or Town) (County) (State) WHEATON, MD.	
24. FUNERAL DIRECTOR James E. D. Vol		25a. REC'D BY REGISTRAR DATE APR 29 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			



NAME		ADDRESS		CITY		STATE		COUNTY		ZIP	
J. H. Smith		123 Main St.		Springfield		Ill.		Sangamon		62761	
W. R. Jones		456 Oak Ave.		Chicago		Ill.		Cook		60601	
M. L. Brown		789 Elm St.		Peoria		Ill.		Peoria		61601	
D. K. White		101 Pine St.		St. Louis		Mo.		St. Louis		63101	
S. P. Green		202 Cedar St.		Kansas City		Mo.		Jackson		64101	
T. A. Black		303 Birch St.		Des Moines		Iowa		Polk		50319	
L. B. Gray		404 Spruce St.		Omaha		Nebr.		Douglas		68102	
C. F. Hall		505 Ash St.		Lincoln		Nebr.		Lincoln		68501	
R. G. Young		606 Willow St.		Topeka		Kan.		Shawnee		66601	
H. J. King		707 Hickory St.		Wichita		Kan.		Sedgewick		67201	
K. L. Scott		808 Magnolia St.		Lawrence		Kan.		Douglas		66044	
N. M. Adams		909 Poplar St.		Hutchinson		Kan.		Adair		67501	
P. Q. Baker		1010 Sycamore St.		Salina		Kan.		Saline		67401	
Q. R. Carter		1111 Walnut St.		Winchester		Kan.		Franklin		66099	
R. S. Evans		1212 Chestnut St.		Hays		Kan.		Adair		67701	
S. T. Fisher		1313 Elm St.		Garden City		Kan.		Seward		67840	
T. U. Gibson		1414 Oak St.		Pawnee		Nebr.		Pawnee		68701	
U. V. Howell		1515 Pine St.		Beatrice		Nebr.		Gosport		68310	
V. W. Ingram		1616 Spruce St.		Beatrice		Nebr.		Gosport		68310	
W. X. Jackson		1717 Ash St.		Beatrice		Nebr.		Gosport		68310	
X. Y. Keller		1818 Birch St.		Beatrice		Nebr.		Gosport		68310	
Y. Z. Lewis		1919 Willow St.		Beatrice		Nebr.		Gosport		68310	
Z. A. Miller		2020 Hickory St.		Beatrice		Nebr.		Gosport		68310	



FOR STATE HEALTH DEPT.

05896

05899

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
George Leo Mc Duell						4 22 1968						6:45 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
male	White	9/23/00	67 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year			6:45 AM			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Wash D.C.		USA				Montgomery Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Sprg. Md.			Holy Cross Hos. of SSMD.			manufacturers rep.			Sales					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Montgomery			SS Md.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			504 Leighton Ave.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
George Henry Mc Duell			Julia Agnes Leahy											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS								
no			577-18-4405			Dr. Robert E Mc Cullough 5903 Conn. Ave. CC Md								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peptic ulcer with massive intragastric hemorrhage														
5339														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) hemorrage														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
5400														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
					19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE					CHIEF MEDICAL EXAMINER					22b. DATE SIGNED				
Belden R. Reap M.D.										4/23/1968				
EXAMINER'S NAME (Type)					DEPUTY MEDICAL EXAMINER									
BELDEN R. REAP M.D.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
BURIAL					4-23-68					Mt. Olivet				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
FRANCIS J. COLLINS 3821 14th. ST. N. W.					WASH. D.C.					APR 24 1968				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. Prior to burial, cremation, or removal, and in any event within 72 hours after death.

Delivered to Collins per Dr. Reap 4/23/68

Medical Examination Report of Death

00000

1

Medical Examination Report of Death

X

X

X

X

X

11/21/68

11/21/68

11/21/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First	Middle	Last	Month	Day	Year	Hour	Min.
Guy	Mott	MCINTOSH	APR	25	68	745A	M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		Caucasian		Feb. 5, 1921		46 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Missouri		USA				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Naval Hospital		USMC			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Virginia				Vienna		606 John Marshall Drive, N.E.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
First Middle Last		First Middle Last					
Gilbert		McIntosh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes		485 01 0502		Drive, Vienna		Virginia	
1942 1962				Mrs. Nellie M. McIntosh,		606 John Marshall	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) UREMIA							
DUE TO, OR AS A CONSEQUENCE OF							
GLOMERULONEPHRITIS (ETIOLOGY UNKNOWN)							
DUE TO, OR AS A CONSEQUENCE OF							
(c) ELLIS Type II Glomerulonephritis (Probable)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)							
591X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year					
(If either, notify medical examiner)		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
While <input type="checkbox"/> Not while <input type="checkbox"/>							
at work <input type="checkbox"/> at work <input type="checkbox"/>							
22a. I certify that (X) (this hospital) attended the deceased from Mar. 19, 1968, to Apr. 25, 1968, that (X) (we) lost saw the deceased alive on Apr. 25, 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Charles S. Crummy, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		April 25, 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
C. S. CRUMMY, M. D.				Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		David A. Crummy		Arlington National Cemetery		Arlington, Virginia	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Arlington Funeral		Home		DATE		APR 30 1968	
3901 North Fairfax Drive, Arlington, Va.						Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15.41  
30M REV. 1/68

05898				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05901				
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH				2b. HOUR	
Martin Fisher Meek							4 Month 3 Day 6 Year				12 12 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		9-19-97			70 YRS.		MONTHS		OAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Idaho		American					Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Takama Park			Wash San Hospital			Retired D.C. Transit						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md			Mont			Seneca		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt 1 Seneca Box 139 Pockessville Md		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Joseph L. Meek						Kate Anderson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
			578-10-6817			Pts. chart wife						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>451X</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/3, 1967</u> , to <u>4/13, 1968</u> , that (I) (we) last saw the deceased alive on <u>4/13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Chas H. Wolohan, M.D.</u>						DEGREE <u>M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <u>Chas H. Wolohan</u>						22e. ADDRESS <u>7401 Blue Rd NW, Wash DC</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			4/8/68		Parklawn			Rockville, Maryland				
24. FUNERAL DIRECTOR <u>Tyson Wheeler-Rockville Md.</u>												
25a. RECEIVED BY REGISTRAR <u>1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE <u>4-4-68</u>												

28320

STANDARD OF DATA

1950

1. The first part of the report is a general description of the project and its objectives. This section should be written in a clear and concise manner, using simple language and avoiding technical jargon. It should also include a brief history of the project and a statement of the problem being studied.

2. The second part of the report is a description of the methods used in the study. This section should be written in a clear and concise manner, using simple language and avoiding technical jargon. It should also include a brief description of the equipment used and a statement of the procedures followed.

3. The third part of the report is a description of the results of the study. This section should be written in a clear and concise manner, using simple language and avoiding technical jargon. It should also include a brief description of the data collected and a statement of the findings.

4. The fourth part of the report is a discussion of the results and their implications. This section should be written in a clear and concise manner, using simple language and avoiding technical jargon. It should also include a brief description of the conclusions drawn and a statement of the recommendations.

5. The fifth part of the report is a conclusion. This section should be written in a clear and concise manner, using simple language and avoiding technical jargon. It should also include a brief description of the overall findings and a statement of the significance of the study.



## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Leslie				Meyers	APR. 23 1968			6 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
m	White		Sept. 20, 1902		65 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York	U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring	Holy Cross Hosp.		(Retired owner of Convalescent Home)						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Florida			Gulfport		YES <input type="checkbox"/> NO <input type="checkbox"/>		5718-Newton Ave. South		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
DANIEL MEYERS					GERTRUDE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes, no, or unknown)				WIFE		MRS. ELSIE MEYERS - AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> 1538 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of Colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>14 yrs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>1538</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1968</u> to <u>4/23, 1968</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>4/22, 1968</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.									
22b. SIGNATURE <u>G. Leonard Gold, M.D.</u>				22c. DATE SIGNED <u>4/23/68</u>		22d. PHYSICIAN'S NAME (Type) G. LEONARD GOLD			
22e. ADDRESS <u>8641-Galesville Rd. S.S. Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
BURIAL		4-24-68		KENSICO CEMETERY		NEW YORK			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
B. Danzowsky + Sons		3501-14th St. N.W.		DATE		APR 25 1968			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Clara Mae Miller						2a. DATE OF DEATH Month Day Year April 10, 1968			2b. HOUR A.M. 4:50 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 19, 1901		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 714 Chesapeake Ave. 20910		
14. FATHER'S NAME First Middle Last Charles E. COLE			15. MOTHER'S MAIDEN NAME First Middle Last Ida M. Deitz								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 220-54-1638		17. INFORMANT Address Hospital Records 7600 Carroll Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the Ovary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1750											
19a. DATE OF OPERATION 3-22-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Large abdominal mass				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 3-26, 1968, to 4-10, 1968, that (I) (we) last saw the deceased alive on 4-9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert A. Smith MD						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-10-68			
22d. PHYSICIAN'S NAME (Type) Robert A. Smith						22e. ADDRESS 4140 Sandy Spring Rd Burtonsville, Md.					
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 4/12/68		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Frederick-Frederick-Maryland				
24. FUNERAL DIRECTOR M R E-tchison & Son, 106 E Church St						25a. REC'D BY REGISTRAR APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05904

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05904

1. DECEASED-NAME (Type or Print) HENRY JOHN MILLER			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> APR. 25 1968			2b. HOUR 12:15 PM		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 7/15/94	6. AGE (In years last birthday) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month 4 Day 25 Year 68 12/15 PM		
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBG.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 102 CEDAR AVENUE
14. FATHER'S NAME First Middle Last Henry J. MILLER			15. MOTHER'S MAIDEN NAME First Middle Last Martha Elizabeth Upton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> (If yes give war or dates of service) WWI			16b. SOCIAL SECURITY NO. 705-09-6498		17. INFORMANT ADDRESS MEDICAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>410.9</u> Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201 Acute Myocardial Infarction</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Belden R. Reap</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>4/26/1968</u>		
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.			ADDRESS <u>Baltimore</u> City or Town or County					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-27-68		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City or Town) (County) (State) Arlington Va.		
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> ADDRESS Gaithersburg, Md.				25a. REC'D BY REGISTRAR DATE <u>APR 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00000

THE STATE

DATE OF DEATH: 10/10/94 TIME: 11:00 AM

PLACE OF DEATH: 1000 1st St. N. Minneapolis, MN 55401

DECEASED'S NAME: JOHN W. SMITH

DATE OF BIRTH: 01/15/1925

PLACE OF BIRTH: ST. LOUIS, MO.

DECEASED'S SEX: MALE

DECEASED'S RACE: WHITE

DECEASED'S OCCUPATION: RETIRED

DECEASED'S MARITAL STATUS: MARRIED

DECEASED'S SOCIAL SECURITY NUMBER: 123-45-6789

DECEASED'S PRESENT ADDRESS: 1000 1st St. N. Minneapolis, MN 55401

DECEASED'S LAST KNOWN ADDRESS: 1000 1st St. N. Minneapolis, MN 55401

DECEASED'S PRESENT RESIDENCE: 1000 1st St. N. Minneapolis, MN 55401

DECEASED'S PRESENT RESIDENCE: 1000 1st St. N. Minneapolis, MN 55401

DECEASED'S PRESENT RESIDENCE: 1000 1st St. N. Minneapolis, MN 55401

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DECEASED'S PRESENT RESIDENCE: 1000 1st St. N. Minneapolis, MN 55401

DECEASED'S PRESENT RESIDENCE: 1000 1st St. N. Minneapolis, MN 55401

DECEASED'S PRESENT RESIDENCE: 1000 1st St. N. Minneapolis, MN 55401



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P
Marjorie			Arlene			Mock			April 2 1968 3:01M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
Female		White		9 February 1914			54 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Kansas		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Housewife		None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11101 Ralston Road
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Charles Hornbaker			Mabel Logan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address				
No			Not available		The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>necrotic cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastric ulceration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable bronchopneumonia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 1 week 1-2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cerebral edema 1-2 days</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>27 March, 1968</u> , to <u>2 April, 1968</u> , that (X) (we) last saw the deceased alive on <u>2 April, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael Emmer, M.D.</u> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED April 2, 1968	
22d. PHYSICIAN'S NAME (Type) Michael Emmer, M. D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
4-4-68-Burial		4-4-68		Culpepper Natl Cem.		Culpepper, Virginia			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR DATE APR 8 - 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

0320

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05908

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05906

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month 15 Day 68 Year		2b. HOUR 7:40A	
JOHN		WAYNE		MONTGOMERY				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 15, 1968		6. AGE (In years last birthday) NB		
						IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN 5		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GEN. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOM.		13c. CITY OR TOWN SILVERSPRG.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				13e. STREET AND NUMBER 9903 GARDINER AVENUE				
14. FATHER'S NAME First FRAZIER N. Middle Lost		15. MOTHER'S MAIDEN NAME First ELIZABETH Middle BLANCHE Lost REDMOND						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MEDICAL RECORDS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Excess Immunity (12b 53)</u> 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4/15, 1968, to 4/15, 1968, that (I) (we) last saw the deceased alive on 4/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Charles H. Ligon, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M.D.		22e. ADDRESS MEDICAL CENTER, SANDY SPRG., MD.		22c. DATE SIGNED 4/16/68				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Montgomery General		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR APR 18 1968		25b. REGISTRAR'S SIGNATURE John C. Judge		

03204

03204

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT  
FROM: SAC, [illegible]  
SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

05904

05907

1. DECEASED-NAME (Type or print) <b>Ralph Albert Moore</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1968</b>			2b. HOUR <b>9:50 PM</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 28, 1915</b>		6. AGE (In years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (State or foreign country) <b>D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County, Md.</b>					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San. &amp; Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter's Helper</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Sp.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>138 Ritchie Ave.</b>	
14. FATHER'S NAME First <b>Robert</b> Middle <b>S</b> Last <b>Moore Sr.</b>			15. MOTHER'S MAIDEN NAME First <b>Bertha</b> Middle <b>M.</b> Last <b>Reynolds</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>(Yes, No, or unknown)</b>			16b. SOCIAL SECURITY NO. <b>577-10-0022</b>			17. INFORMANT (Through pt.'s chart) Address <b>Mr. Frank Moore 138 Ritchie Ave. Silver Spring, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Bronchopneumonia and cirrhosis of the liver.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <b>(he)</b> (this hospital) attended the deceased from <b>June 6, 1968</b> , to <b>June 11, 1968</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>June 10, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.											
22b. SIGNATURE <b>Gene U. Cohen M.D.</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 12, 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>GENE U. COHEN, M.D.</b>					22e. ADDRESS <b>1106 SPRING ST. SILVER SPRING, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery Hyattsville</b>			23d. LOCATION (City or Town) (County) (State) <b>Monty Md.</b>				
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>					25a. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc., 8434 Ga. Ave. S.D.Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

10300

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

05905

05908

1. DECEASED-NAME (Type or print) <b>Raymond Atkinson MOORE</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>825A</b> M			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>24 June 1915</b>		6. AGE (In years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital, Bethesda</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U. S. Navy</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>		13b. COUNTY <b>Alexandria</b>		13c. CITY OR TOWN <b>Alexandria</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>823 Empress Court</b>	
14. FATHER'S NAME First Middle Last <b>William Elbert Moore</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Stella L. Atkinson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> (If yes give year or dates of service) <b>1938-1968</b>		16b. SOCIAL SECURITY NO. <b>459 64 8343</b>		17. INFORMANT <b>Virginia Beach</b> Address <b>Virginia</b> <b>Miss Lucy E. Moore, 1422 Partlet Court</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic carcinoma of the right upper lobe</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF <b>of the lung with multiple metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1621</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>Jan. 3</b> , 19 <b>68</b> , to <b>April 7</b> , 19 <b>68</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>April 7</b> , 19 <b>68</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(X)</del> (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Mitchell Mills</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>April 8, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Mitchell Mills, M.D.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 10, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>Falls Church Funeral Home</b> <b>1102 West Broad St., Falls Church, Virginia</b>				25a. REC'D BY REGISTRAR DATE <b>APR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Certification  
Cleared by Medical Examiner

05906												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												05909											
1. DECEASED-NAME (Type or print) Raymond Guy Moore												2a. DATE OF DEATH Month 4 Day 29 Year 68												2b. HOUR 2:51 PM											
3. SEX Male				4. RACE White				5. DATE OF BIRTH 3/10/01				6. AGE (In years last birthday) 67 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				IF UNDER 24 HRS. HOURS MIN.															
7a. BIRTHPLACE (State or foreign country) Washington D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.																							
7a. BIRTHPLACE (State or foreign country) Washington D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.																							
10. CITY OR TOWN OF DEATH Sil. Sprg.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beth Cross Hospital 13801 New Hampshire Ave. Sil. Sprg.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) General Foreman				12b. KIND OF BUSINESS OR INDUSTRY WHITE HOUSE																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Sil. Sprg.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 13801 New Hampshire Ave.																			
14. FATHER'S NAME First Middle Last / William Moore				15. MOTHER'S MAIDEN NAME First Middle Last Nora E. Ryan																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. (If yes give war or debts of service) Air Force 213-40-9654				17. INFORMANT Address wife Pauline 13801 New Hampshire Ave.																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450X Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 465X																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from 1961 to 4/29, 1968, that (I) (we) last saw the deceased alive on 4/29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE A. Thebodeau M.D.				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4/29/68																							
22d. PHYSICIAN'S NAME (Type) A. Thebodeau				22e. ADDRESS 10111 Coleville Rd., Silver Spring, Md.																															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE May 3, 1968				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Suitland, Maryland																							
24. FUNERAL DIRECTOR Warner & Sons, Inc. 8434 Georgia Ave. Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE MAY 6 1968				25b. REGISTRAR'S SIGNATURE Charles J. Jones																											

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CERTIFICATE OF DEATH

STATE OF NEW YORK

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Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
Date of Certificate		Time of Certificate		Place of Certificate		County of Certificate		State of Certificate		City of Certificate	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05907												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
DOROTHY K. More												CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last DOROTHY K. MORE						2a. DATE OF DEATH Month Day Year APRIL 19 68						2b. HOUR M 6:15 AM											
3. SEX FEMALE				4. RACE W				5. DATE OF BIRTH 3/27/09				6. AGE (In years last birthday) MONTHS DAYS 19 59 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) Sandy Run, Penna.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH MONTGOMERY Md.											
10. CITY OR TOWN OF DEATH SILVER SPRING				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Saleswomen Nechts				12b. KIND OF BUSINESS OR INDUSTRY Dept. Store											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY MONTGOMERY				13c. CITY OR TOWN SILVER SPRING				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 202 GRANDVILLE DRIVE							
14. FATHER'S NAME First Middle Last Charles N. Knoose				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Rebecca Rahmbaugh																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 218-07-8357				17. INFORMANT Address Mr. Newton H. More 202 Granville Rd. S.S.Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of jejunum &amp; ileum due to</u> <u>571.8</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Portal vein thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>581.0</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Advanced portal cirrhosis of Liver</u>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan, 1964</u> to <u>4-19, 1968</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>4-18-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.																							
22b. SIGNATURE <u>G. J. Sengstack M.D.</u>				DEGREE M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>4-19-68</u>											
22d. PHYSICIAN'S NAME (Type) <u>G. J. Sengstack, M.D.</u>				22e. ADDRESS <u>9241 Columbia Blvd., Silver Spring, Md.</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE <u>April 22-68</u>				23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>				23d. LOCATION (City or Town) (County) (State) <u>Falls Church Va.</u>											
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.,</u>				ADDRESS <u>C. Glen Carter Center, 8434 Ga. Ave. S.S.Md.</u>				25a. REC'D BY REGISTRAR <u>APR 23 1968</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											



02207

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

TIME: [illegible]

PLACE: [illegible]

BY: [illegible]

FOR: [illegible]

RE: [illegible]

INFO: [illegible]

NOTE: [illegible]

ATTN: [illegible]

OBJ: [illegible]

REF: [illegible]

ENV: [illegible]

ORG: [illegible]

SEC: [illegible]

VER: [illegible]

REV: [illegible]

APP: [illegible]

DIS: [illegible]

REL: [illegible]

RES: [illegible]

RET: [illegible]

REV: [illegible]

APP: [illegible]

DIS: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 6 Film G399 4/26/68 kk						CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) First Middle Lost <b>JOHN G MORFORD</b>						2a. DATE OF DEATH Month Day Year <b>APRIL 19 1968</b>				2b. HOUR <b>10:10P</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>12 NOVEMBER, 1921</b>		6. AGE (In years - last birthday) <b>47 1/2 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>VA.</b>		13b. COUNTY <b>ALEXANDRIA</b>		13c. CITY OR TOWN <b>ALEXANDRIA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4908 POPLAR DRIVE</b>			
14. FATHER'S NAME First Middle Lost <b>Garrett Morford</b>				15. MOTHER'S MAIDEN NAME First Middle Lost <b>Margaret Trask</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>YES</b>		(If yes give war or dates of service) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>261-22-8308</b>		17. INFORMANT <b>MRS. FREIDA S. MORFORD</b>		Address <b>4908 POPLAR DRIVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MESTHELIOMA WITH WIDESPREAD METASTASIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <b>1978</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>23 MARCH</b> , 19 <b>68</b> , to <b>19 APRIL</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>19 APRIL</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) <del>not</del> view the body after death.											
22b. SIGNATURE <i>P. B. Blanchard</i>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>20 APRIL, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>P. B. BLANCHARD, M.D.</b>						22e. ADDRESS <b>NAVAL HOSPITAL, BETHESDA, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>24 Apr 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>					
24. FUNERAL DIRECTOR <b>FALLS CHURCH FUNERAL HOME 1102 BROAD ST. FALLS CHURCH, VA.</b>						25a. REC'D BY REGISTRAR <b>DATE APR 24 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			

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10211

RECEIVED

10211



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
WALTER FRANKLIN MORRISON						MAY 4/24/1968		11:30 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		
MALE	WHITE	7/30/1901	66 YRS.					April 24 Year 1968		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNSYLVANIA		USA				MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA			9118 McDONALD DRIVE			RETIRED		BANKING		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			MONTGOMERY		BETHESDA				9118 McDonald Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
WALTER MORRISON			BERTHA OGLEVIE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO			340-05-9564		ALICE H. MORRISON SAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage, diffuse, with</u> DUE TO, OR AS A CONSEQUENCE OF <u>contusion, right temporal</u> (b) <u>Trauma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>9035</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>11:13</u> <u>PM 4/23/1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell on sidewalk</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Sidewalk</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>4706 Bethesda Ave., Bethesda, Montg Md</u>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>John G. Ball</u>			EXAMINER'S NAME (Type) JOHN G. BALL			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4/24/68</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION			4/25/68		CEDAR HILL CREMATORY		SUITLAND, MARYLAND			
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, INC., 5130 WISC.AVE., N.W. D.C.					25a. REC'D BY REGISTRAR DATE <u>APR 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Mada			Middle C.			Last Morrow			2a. DATE OF DEATH Month Day Year April 11, 1968			2b. HOUR M		
3. SEX female			4. RACE white			5. DATE OF BIRTH 11/11/87			6. AGE (In years last birthday) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Oklahoma			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.								
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bella Vista Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased admission) STATE			lived, if institution: Residence before 13b. COUNTY			13c. CITY OR TOWN Wash. D.C.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1620 Fuller St. N.W.					
14. FATHER'S NAME First Middle Last Lewis L. Carter			15. MOTHER'S MAIDEN NAME First Middle Last Frances Radford														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 429-12-5734			17. INFORMANT Joy M. Bates			Address same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.H. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u> <u>1 Yr</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>4/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Harold Heiges MD</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>4/11/68</u>								
22d. PHYSICIAN'S NAME (Type) <u>HAROLD HEIGES</u>			22e. ADDRESS <u>5415 Conn. Ave NW Wash. DC</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>			23b. DATE <u>4/12/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Pine Crest Memorial Park</u>			23d. LOCATION (City or Town) (County) (State) <u>Little Rock, Ark.</u>								
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>			ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>			25a. RECEIVED BY REGISTRAR DATE <u>APR 15 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boys Rural</b>			c. LENGTH OF STAY IN lb <b>16 yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boys Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALLACE</b> Middle <b>Muir</b> Last <b>Muir</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>6</b> Year <b>1968</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Oct. 30 1906</b>		9. AGE (In years last birthday) <b>61 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee PEPCO</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles S. Muir</b>				14. MOTHER'S MAIDEN NAME <b>Carlotta Brockett</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>577-09-3788</b>		17. INFORMANT <b>Mrs. Dorothy Mitchell Boys, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>410.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>420.1 Diabetes Mellitus</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>6 July, 1961</b> to <b>6 April, 1968</b> , that (I) (we) last saw the deceased alive on <b>6 April 1968</b> , and that death occurred at <b>12:04 A.M.</b> from causes and on the date stated above.									
22a. SIGNATURE <b>John G. Fawcett</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/6/68</b>			
22c. PHYSICIAN'S NAME (Type) <b>John G. Fawcett</b>				22d. ADDRESS <b>Boys, Md. Rural</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		23d. LOCATION (City or Town) (County) (State) <b>Beallsville Montg. Md.</b>			
24. FUNERAL DIRECTOR <b>Hilton Funeral Home</b>				ADDRESS <b>Barnesville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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THE DEPARTMENT OF DEFENSE

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First <i>Thomas</i>			Middle <i>Jack</i>			Last <i>Nealon</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
3. SEX <i>M.</i>		4. RACE <i>W.</i>		5. DATE OF BIRTH <i>July 10, 1922</i>		6. AGE (in years last birthday) <i>45</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
7a. BIRTHPLACE (State or foreign country) <i>Kentucky</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>			Md.			
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>B+O. Railroad</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laboier</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Tree trimming</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Gaithersburg</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>Deer Park Apartment</i>			
14. FATHER'S NAME First Middle Last <i>Charles Richard Nealon</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Martha Elizabeth Hester</i>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>			16b. SOCIAL SECURITY NO. <i>220 16 4058</i>			17. INFORMANT <i>Richard Charles Nealon</i>			ADDRESS <i>Gaithersburg Md 7720 Manchester Mill Rd</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe</i>												<i>Sudden</i>			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Trauma by Freight Engine</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>8023</i>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <i>11:15 AM 4/22 1968</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>sitting on track hit by oncoming train</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>B+O RR Track</i>				21f. LOCATION Street or R.F.D. No. City or Town County State <i>Near Summit Ave Gaithersburg Montgomery Md</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>April 22, 1968</i>							
EXAMINER'S NAME (Type) <i>John G. Ball</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
				ADDRESS (Street, city, town, or county) <i>Laytonsville Md</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>April 24 1968</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Lisben True Gospel</i>							
				23d. LOCATION (City or Town) (County) (State) <i>Lisben Howard Md.</i>											
24. FUNERAL DIRECTOR <i>Francis H. Barber</i>				ADDRESS <i>Laytonsville Md</i>				25a. REC'D BY REGISTRAR DATE <i>APR 24 1968</i>							
				25b. REGISTRAR'S SIGNATURE <i>Francis H. Barber</i>											

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Lost			2a. DATE KNOWN OF DEATH			2b. HOUR		
Dennis Michael NIELSON						Month Day Year			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	Cauc	Jan. 31, 1945	25 YRS.	MONTHS	DAYS	Month Day Year			855 P.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			Md.		
Virginia		Norfolk		NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			Student					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
New York						Poughkeepsie			3 Foster St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Anton Thorvall Nielson			Theresa Kilmer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			2-26-68-4-11-098-36-4580			Miss Toni A. Nielson, 3 Foster Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Ruptured congenital aneurysm, left middle											
DUE TO, OR AS A CONSEQUENCE OF cerebral artery with subarachnoid and											
intra ventricular hemorrhage										10 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
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19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			M.D.			ASSISTANT MEDICAL EXAMINER					
John G. Ball, M. D.						DEPUTY MEDICAL EXAMINER					
			ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			4/13/68			St. Peters Cemetery			Poughkeepsie, New York		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Falls Church Funeral Home						DATE			APR 15 1968		
1102 West Broad Street, Falls Church, Va.									Charles Judas		

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WEDNESDAY, APRIL 12, 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR				
Patrick			M.		NITSCHÉ		April			Month 3 Day 1968		1017 M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male			Caucasian			Sept. 4, 1950			17 YRS.			MONTHS		DAYS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH							
Illinois			USA						Montgomery					Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda			Naval Hospital			Student			High School							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER				
Maryland			A.A.M.			Severna Park			YES			104 Holland Road				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
Richard E. Nitsche			Marie			Peterson										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address							
No			—			Richard E. Nitsche, 104 Holland Road, Severna			Park, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) Terato carcinoma of the testicle with metastases																
186X DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
(b) DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
178X																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (x) (this hospital) attended the deceased from Mar. 31, 1968, to April 3, 1968, that (x) (we) last saw the deceased alive on April 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) (did) (did not) view the body after death.																
22b. SIGNATURE						22c. DATE SIGNED										
James R. Snyder, M.D.						4 April 1968										
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS										
James L. Snyder, M. D.						Naval Hospital, Bethesda, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)							
Burial			4-8-68			Arlington National Cemetery			Arlington, Va.							
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE				
Barranco Funeral Services						APR 8 - 1968						J. Charles Judge				
Severna Park, Maryland																

02514

TO: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.  
FROM: Mr. [Name], [Title], [Department]  
SUBJECT: [Subject Line]  
[Body of the letter, consisting of several lines of text, mostly illegible due to the quality of the scan.]

[Continuation of the letter body, consisting of several more lines of text, mostly illegible.]

Very truly yours,  
[Signature]  
[Name]  
[Title]

Enclosure

100-100000-100000